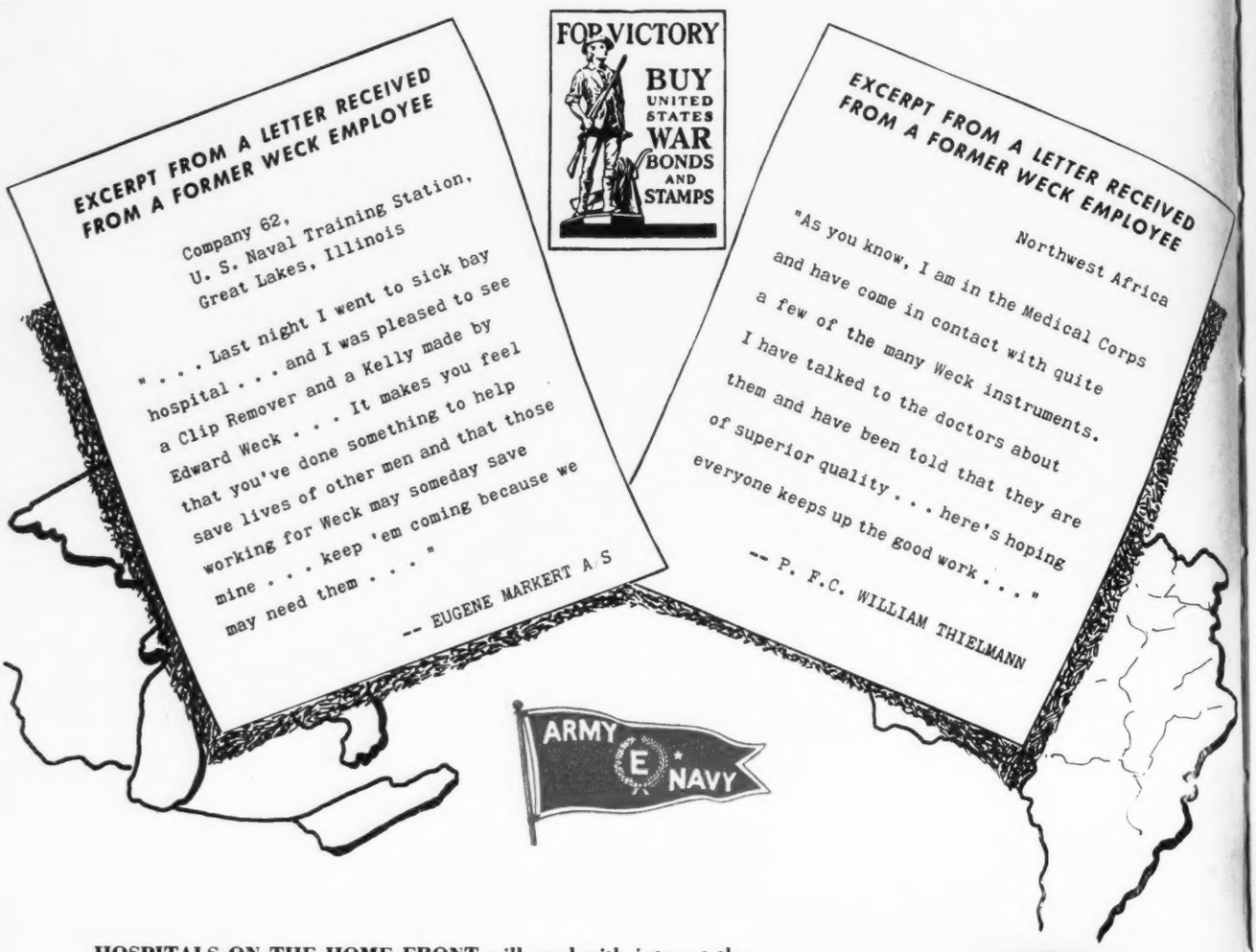
the MODERN HOSPITAL

VOLUME 60 JUNE 1943 NUMBER 6

Good Advice FROM TRAINING CAMPS AND NORTH AFRICAN FRONT



HOSPITALS ON THE HOME FRONT will read with interest the excerpts above from two of the several Weck craftsmen now in our armed forces. On all fronts — training camps, North Africa, Europe, the Far East, Weck surgical instruments are serving on a constantly widening circle. Surgeons everywhere find the words of these Weckmen wise — "keep 'em coming." Day and night, week in and week out, for two years Weck has been working to do just that. If you find difficulty in getting all the Weck-made instruments you need we know you will cooperate with us — the needs of our men on all fighting fronts must come first. Meanwhile, perhaps the Weck repair service can aid you; and finally the best advice of all: BUY MORE U. S. WAR BONDS AND STAMPS.

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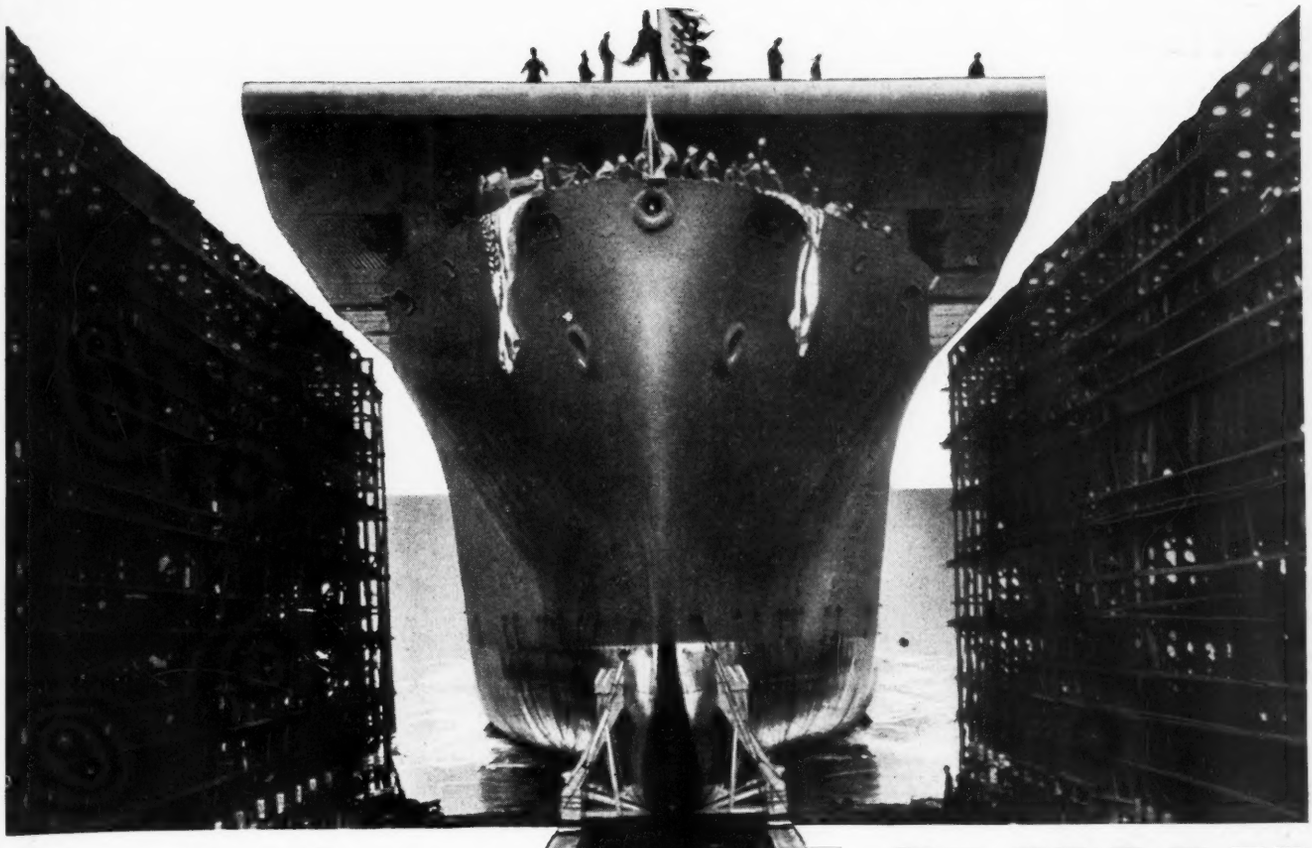

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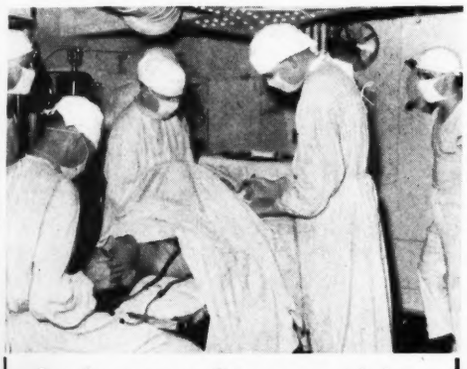

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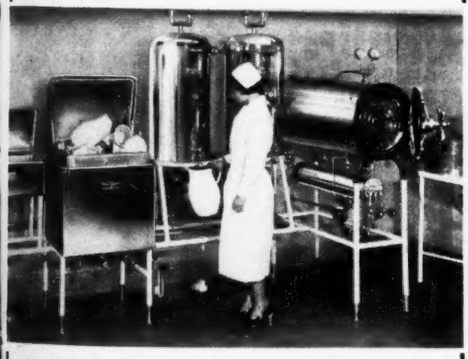

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CONTENTS

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EDITORIAL BOARD

"AN OUNCE OF PREVENTION!"

IN INDUSTRY accidents are best treated by not allowing them to happen. The same practice is followed in surgery where an ounce of prevention often will obviate the necessity of a costly cure. Perhaps it's an extra day of pre-operative care or a blood transfusion wisely administered. Sometimes it's only a hurried preparation of the operative field. In any event, one important step is avoidance of infection, a matter in which 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly) is a very generous "ounce of prevention."

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BUY WAR BONDS AND STAMPS

THE ROVING REPORTER

V.O.C.

The pioneering work has all been done so hospitals that want to get onto the Volunteer Orderly Corps bandwagon have only to follow the leader.

The leader is White Plains Hospital, White Plains, N. Y., where professional and business men have organized themselves into a companion service of the Nurses' Aide Corps and are functioning as orderlies in the evening hours and on Sundays.

The V.O.C. was a spontaneous organization among responsible citizens of the community who did not want to see their wives and daughters getting all the fun, hard work and credit for volunteer hospital service. So they organized, drew up a list of qualifications, instituted a 20 hour training course and have set down a list of 40 approved duties.

Let's look at the plan more closely. The White Plains V.O.C. operates on an invitational membership basis only, although it believes that other hospitals may wish to call publicly for volunteers provided they control the final selection. The men are from 35 to 45 years old; consequently they are not eligible for early Army induction and yet are active physically.

Each corpsman serves a minimum of three hours per week. Sixteen men are on duty at the hospital between the hours of 7 and 10 p. m. Monday through Saturday; the Sunday hours are in the daytime. They serve under a captain who has a list of substitutes from whom to draw in case a volunteer orderly sends word that he cannot serve on a certain evening.

Under the White Plains setup the men, after fifty hours of training and duty, become members of the local Civilian Defense Corps.

Hospitals wishing to use the White Plains plan as a framework for a similar program of their own may write to the Director of V.O.C., 19 Midland Avenue, White Plains, N. Y. They'll get all the information they want—and gladly.

24 Hour Maternity Care

The Army and Navy "E" for war production exceeding anticipated quotas might well fly over every hospital maternity department in the land.

Having reached the outside limits of their capacity, many hospitals are considering earlier discharge of normal postpartum patients. Read what is being done at Elkhart General Hospital, Elkhart, Ind.

Fifty per cent of all maternity patients leave the hospital twenty-four hours after delivery. No untoward results have been reported although 450 cases were given this quick a discharge during 1942.

Relates Amy J. Daniels, R.N., the superintendent: "Our hospital is too small to accept the increasing number of maternity cases for the usual period. We could use another 100 beds if we had them. On the other hand, our town has six ambulances, well heated and comfortable.

"On the theory that it is better for a woman to be delivered of her child in the hospital where facilities are available in case of emergency than in her own home, we accept all maternity patients. Half of them are discharged at the end of the first twenty-four hours. In their own homes they are cared for, probably, by their mothers with daily visits from either Red Cross or public health nurses. It is doubtful whether the doctors, rushed as they are, can see the patients more than every few days.

"You ask how student nurses get the necessary training in postpartum work? The answer is that we have no nursing school."

Knock! Knock!

The patients shudder yet the noise keeps recurring. Nobody does anything about it.

Wills Hospital, Philadelphia, admits the allegation but is attempting to do something about it by broadcasting some statistics to the personnel.

It happens in every institution but let's confine this account to Wills, which furnishes the inspiration for this item from the Roving Reporter's notebook.

For many days patients throughout the building were annoyed by a knocking, screeching water faucet. Whenever someone opened that faucet, the vibrations carried all over the house. Yet no one operating the faucet ever bothered to report to the office this offense to the auditory sense.

At length the limit of toleration was reached and no report having reached the engineer's office as to the offending faucet, the chief engineer and the plumbing engineer set out to check every faucet in the 200 bed institution. It took six man hours to locate the culprit and then only five minutes to correct the defect. A nurse or a maid could have reported it in one minute.

"Thoughtful cooperation is in order at all times," Supt. Melvin L. Sutley told the Wills personnel in reporting the incident, "but never more so than now, in war time."

Soldier's Friend

Not all of the contact work between troubled soldiers and their families is done by the Red Cross. Occasionally the hospital gets a chance to share in this rewarding type of morale service.

Furlough over, a New York City private arrived at St. Luke's Hospital two hours before train time with his sick wife and 2 weeks old infant. One hour later the 22 year old soldier was on the way to the train that was to take him to Florida, knowing that his little family was to be well taken care of.

During that one hour doctors, nurses, admitting officers, volunteers and social workers had sprung into action. The Red Cross had been notified, in case it became necessary to seek an extension of the soldier's furlough. The parish priest had been telephoned and he promised to visit the patient.

While the mother received treatment and advanced toward convalescence and discharge, the social service department sent cheery bulletins to the husband. Not wishing to be left out, the hospital's photographic department volunteered to take a picture of the baby so the soldier-father had a glad surprise when the mail brought him a professional camera study of the "most beauitful baby in the world."

Why not match this St. Luke's tale with one of your own hospital's service to our fighting forces? Address your letter to the Roving Reporter.

Over Fifty Club

The aged porters can't climb step-ladders or lift heavy loads, yet they are better than no porters. The older women who are maids may be slow but most of them are faithful. Without them many a hospital would have to close its doors for the duration.

Decatur and Macon County Hospital, Decatur, Ill., is one of those institutions near a munitions factory that had to go into the "Over Fifty" brackets in order to get anyone at all to fill its jobs.

Nor was this all, we can take Supt. Frank W. Hoover's word for it. The administration had to revise its thinking on a lot of subjects before its employment became somewhat less acute.

Hours had to be changed to meet bus schedules; old rules had to be relaxed (many of them were obsolete or unnecessary anyway); the cafeteria had to be opened to employes who wished to bring their lunches (some hospital coffee is an accompaniment), and other concessions had to be made (most of them not too painful).

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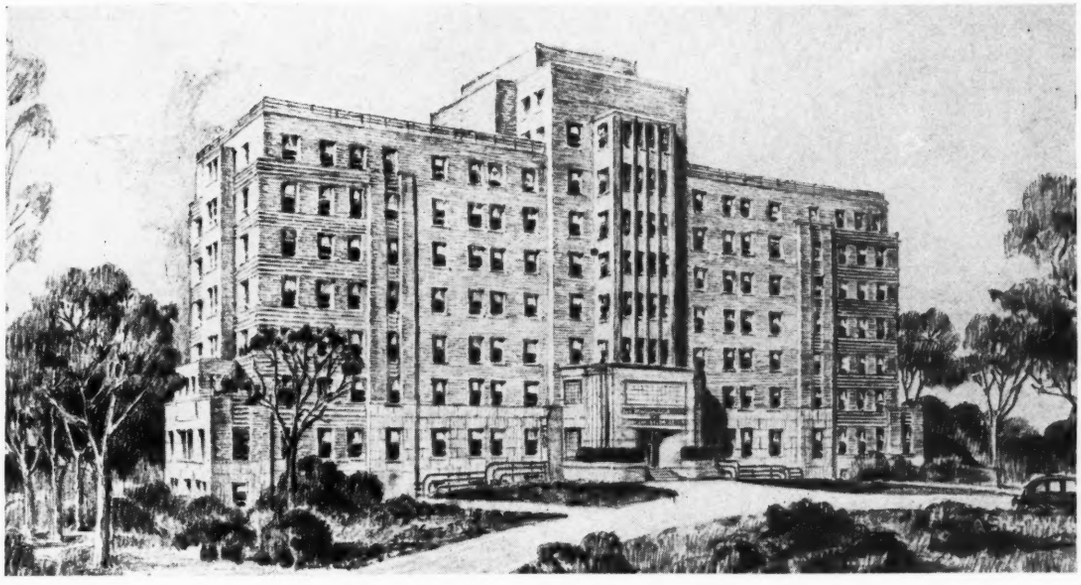

THE NEW MEMORIAL HOSPITAL OF SPRINGFIELD, ILL.

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READER OPINION

Needs Salary Figures

Sirs:

I am interested in salaries and hours of work for R.N.'s, practical nurses and orderlies and also in the increase in bed use because of hospitalization.

We are to have meetings to discuss fairer salaries and hours and we want to be armed with figures that talk. Night nurses work sixty hours per week. They have no holiday time and receive no more pay than day workers. Day nurses work forty-seven and one half hours per week with holiday time.

Have you any figures or magazine articles you can give or lend me?

Also, who should supply the searchlight batteries night nurses must use if they would not flood the ward with light to give a couple of pills? The hospital says it cannot buy batteries (none to be had). We can walk across the street to buy batteries on the corner, but should we have to?

B. C., R.N.

Brooklyn, N. Y.

The American Nurses' Association has recently published a survey of nurses' salaries in hospitals which should be of assistance to you.—Ed.

Voiced "in Service"

Sirs:

I entered the Army December 1 at Camp Grant, Ill., when the weather was below zero. The first month consisted of drilling and hikes along with classes to teach everything but hospitalization.

But when it was all over you could see the reason for doing it. You often say to yourself "What the hell does the Army mean by teaching me this?" But, in the long run, there is a reason.

On January 1, I was transferred to the Valley Forge General Hospital, which at that time was not completed; we had the opening on February 22.

The people back home say, "The Army is getting everything," and, to a certain extent, that is true. But this hospital has to operate on about one third what it should have.

In a place like this where you see the boys coming back deformed and maimed in all different ways you are glad to play a part in helping take care of those who have taken the chance of their lives to save democracy. When I see these boys I only wish that I had bought more bonds. To the unions that are striking on defense jobs, I say I don't think there is anything else that is more un-American than to strike. The boys that are coming back have something to say about such affairs and they should have.

This hospital is very educating. You don't have the opportunity to apply things as much as you would in a private or state hospital but, at the same time, you are able to collect ideas that can be put in use.

Lt. Clarence E. Griffith

Phoenixville, Pa.

Helps for Building

Sirs:

I am a member of a committee that has been set up in our country to raise funds with which to build a hospital when materials and labor are available.

The proposed hospital would be of 50 or 60 bed capacity. If you can furnish any information, such as possible cost of building and equipment, floor plans or pictures of similar-sized hospitals that could be used as a basis for establishing and promoting this program, I would appreciate such information.

John L. Van Metre, M.D.

Charles Town, W. Va.

The cost of a well-equipped 50 or 60 bed hospital will usually run from $3000 to $6000 per bed depending upon (a) the completeness of the institution, i.e. whether a nurses' home, a laundry, an out-patient department and a pharmacy are provided; (b) the simplicity or luxury with which it is planned, and (c) the cost of labor and materials at the time and in the place where it is built.—Ed.

Should Head Be an M.D.?

Sirs:

Do you feel that the head of a hospital should be a man with an M.D. degree? Some of the Army people have argued with me that a hospital cannot be administered properly without an M.D. at the head of it. This, to me, is ridiculous notwithstanding the fact that I have the degree myself. Administration looks to me like a job for a business man. However, you are skilled in this field and I am not and I will welcome your opinion.

H. Evert Kendig, M.D., Dean

School of Pharmacy
Temple University
Philadelphia

The American College of Hospital Administrators has wisely focused the attention of people in the field of hospital administration not upon the fact of presence or absence of a medical degree but rather upon the individual's personal qualifications for administering a large organization composed almost equally of medical, financial, social elements.—Ed.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Sick Leave Is Insurance

Question: Do many hospitals pay the employe the sick leave allowed annually if no time is lost during the year because of illness? How many allow this time to accumulate over a period of years and in the event the employe leaves (not having lost any time because of illness) pay the employe for this time?—J.O., Miss.

ANSWER: Hospitals do not pay an employe his annual sick leave allowance in cash if he was fortunate enough to stay healthy. Sick leave is provided by an employer to allow for a contingency that may occur. If it does not occur, there is no occasion to allow sick leave. Sick leave is, in a sense, a form of health insurance on which the employe may not cash in as long as he stays well. This principle was copied by philanthropic institutions from the practices of industry.

It is not the policy of most hospitals to permit the accumulation of sick leave but the longer the worker remains in the employ of the hospital the stronger is his claim for better treatment during illness. If, for example, an employe has worked for five years in good health and succumbs to illness that lasts two months, the hospital would be making a good investment by paying him full salary or the greater part of it. Kindness to an employe during illness is repaid many times over in subsequent service.

Employes who leave the hospital after several years of service in good health should not be entitled to any cash bonus as a reward for having remained well. The principles underlying sick leave do not parallel ordinary vacation leave.—E. M. BLUESTONE, M.D.

Increasing Vacation Time

Question: Should vacation time be increased according to the time the nurse remains on the staff?—E.McK., T.H.

ANSWER: A few hospitals increase the vacation term with each five year period. —ADA BELLE MCCLEERY.

Problem of Visiting

Question: What is the best procedure to follow in keeping visitors and children under 12 years of age from the obstetrical department?—M.F.B., Ont.

ANSWER: This situation has been met quite successfully at Women and Children's Hospital, Chicago, by issuing passes to the visitors. The husband of the patient is given a permanent pass (a card bearing his name and the room number of his wife) which entitles him to visit her during visiting hours, afternoon and evening. In addition to the husband, each obstetrical patient is allowed two adult visitors every twenty-four hours.

Passes are issued for these visitors and may be used either afternoon or evening, but if the patient has had two visitors in the afternoon, she can have no more until the following day. The fact that a Chicago Board of Health ruling limits visitors to obstetrical patients to two every twenty-four hours helps us materially in carrying out these limitations.

Hospital receptionists carefully explain that no children under 12 are admitted to the obstetrical floor as a protection to the health of the patient. Children 12 years old and over are permitted on the floor on Saturdays and Sundays only.

We have consulted several obstetricians and they all agree that this is as satisfactory a way as any to handle this situation.—MRS. JOCLYN GERRY.

Contracts Don't Help

Question: Should the key personnel of a small general hospital be under contract? What other methods might help prevent increase in personnel turnover?—L.C.D., Va.

ANSWER: A contract will not necessarily hold an employe if he makes up his mind that he wishes to move. The employer is usually put in the position of definitely standing in the employe's way if he refuses to release him from the contract when he wants to go to a better position. This refusal in itself causes resentment on the part of the employe and morale is necessarily affected. The greatest advantage of the contract is for the employe because it gives him a certain security that he will not be arbitrarily discharged.

As to other methods that might help prevent increase in personnel turnover, there are several suggestions. First, these people must be paid wages that are in line with wages paid workers in like work. I do not mean that the high salaries paid the workers in the defense plants must be met, but at least some effort must be made to help employes meet the increased costs of living.

Second, these "key" people must not be allowed to become discouraged by lack of appreciation and cooperation from the hospital administrator in helping them to handle their problems. With the many restrictions now in force, they may begin to feel so hampered and ineffectual that they may be easily weaned from their positions. If, on the other hand, the administrator uses every effort to help them by seeing that everything humanly possible is done to attract workers for the "key" people and to give them the necessary supplies, even though these have to be substitutes, there will be less temptation to be attracted away from their jobs.

Third, it would probably help to promote a few faithful employes into subexecutive positions so as to give "key" people more assistants to help them handle the increasing number of persons who have to be trained quickly if any good is to be obtained from them before they leave the hospital for other employment.—NELLIE GORGAS.

Planning for Staff Help

Question: When nurses come in for a few days or weeks to help out the hospital staff, is it customary to pay them by the day or are they paid at the same rate as the girls they relieve? If the latter, does that mean they are given one day off each week? What is the usual rate of pay for the extra general duty nurse? We have been paying $3 a day with meals and laundry.—E.W., Mont.

ANSWER: In this community it is the custom in all our hospitals to pay a slightly higher rate per day if the nurse is employed for a period of five days or less. Usually, if the employment extends beyond five days, the nurse is considered a regular salaried worker and is paid at the prevailing weekly or monthly salary rate.

The temporary worker, employed for five days or less, is paid at a rate approximately 50 cents per day higher than the monthly rate reduced to its average per day on duty. For instance, if the monthly salary rate for a given type of work is $137.50 (without maintenance) and the nurse is on duty twenty-five days, her per diem rate is $5.50.

If a relief nurse is employed for a period of from one to five days for the same work, she is paid $6 per day for the short period; if her employment extends over a longer period, she then becomes a regular staff nurse and the monthly salary rate is applied.—R. W. NELSON.

When Should Charges Start?

Question: Should patients be charged from the day of admission or the hour of admission?—A.P., Mich.

ANSWER: It is immaterial which method is used as long as the patient is not charged twice for the same period.—ADA BELLE MCCLEERY.

HEADLINE NEWS

JUNE 1943

Student War Nursing Bill Passed by House of Representatives on May 14

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—The imperative present, near future and postwar needs for more nurses; the fact that the government-sponsored program is designed for the duration only and that its primary purpose is to stimulate enrollment of young women in schools of nursing, and the need for maintaining nursing standards were the principal points stressed at the public hearings on the Student War Nursing Reserve Bill held May 6 and 7 in both House and Senate. The bill passed in the House of Representatives on May 14.

Rep. Frances P. Bolton, who introduced the bill in the House, declared that there is a shortage of 108,000 nurses.

Dr. Warren F. Draper, assistant to the surgeon general, U. S. Public Health Service, announced that by June 1944 some 372,000 graduate nurses, all told, will be in demand. With approximately 16,000,000 women going into industry, the new proposed legislation must of necessity be a radical departure, Doctor Draper pointed out, in order to provide new incentives for women to enter the nursing profession. An advisory committee to the Surgeon General would be a means of maintaining high nursing standards.

There was convincing rebuttal to the one possible argument against the bill, *i.e.* that the cessation of the war might leave thousands of young women, thus intensively trained, jobless. Rehabilitation of wounded soldiers, increasing demand for hospitalization through the popularity of Blue Cross plans, the redistribution of populations dislocated by war industries and other urgent postwar emergencies are expected to provide nurses with work for many years.

We are going to have a great responsibility in seeing that there are no devastating epidemics in other parts of the world, warned Rear Admiral Ross McIntire. For a time, at least, the armed forces must keep up the war-time strength of their medical departments. That means that many of these reserve nurses must be kept on active duty for an indefinite period after the war is over.

The measure, now known as H. 2664, was approved May 12 by the House interstate commerce committee.

O.P.A. Officials Aid Hospitals by Easing Food Rationing Rules

WASHINGTON, D. C.—Studies of the food rationing problems of hospitals are still being conducted with hope that the most satisfactory methods of meeting the situation will shortly be announced, it was stated by Dr. Archie M. Palmer, associate director of food rationing, O.P.A., in an interview with the Washington representative of The MODERN HOSPITAL given May 18.

On Saturday, May 22, the subcommittee on medical food requirements of the Committee on Drugs and Medical Supplies, National Research Council, met with Doctor Palmer. On May 24 he conferred with representatives of the hospital associations.

Although the outcome of these conferences may not be announced by the time this magazine goes to press, several amendments to General Rationing Order 5 have already eased difficult situations.

On May 4 Amendment 19 made it possible in certain cases for institutional users who have unbalanced stocks in inventory to get a reasonable quantity of particular types of foods needed. Amendment 20, issued on May 10, covers home processing by institutional users and in amendments on the same date to G.R.O. 3 provision is made for gifts of canned fruits and vegetables up to a certain amount without loss to the institution of any points.

Hospitals were relieved that Amendment 21, issued May 15, cut the minimum dollar revenue increase needed by institutional users to obtain supplemental food allotments from 20 to 10 per cent.

Fats and Oils Available

WASHINGTON, D. C.—Hospitals that need meats and fats for other than food purposes, *e.g.* cottonseed oil for bathing and massaging patients, can now be classed as industrial consumers for such purposes even though the use does not result in a manufactured product, according to an amendment to R.O. 16 adopted on May 20. Applications for fats and oils go to the Food Distribution Administration in Washington; for other rationed foods they should be sent to O.P.A. district offices.

Preference Ratings on Films Are Limited by W.P.B. Order 8, May 14

WASHINGTON, D. C.—In an action affecting rated orders of institutional and other users of photographic film, W.P.B. on May 14 limited the use of preference ratings for purchase of film to those assigned on Forms PD-1A, PD-3A and so on. Hospitals are to apply to field offices on PD-1A and, to be valid, ratings assigned on these forms must be AA-5 or higher. Instructions have been issued to extend ratings of not less than AA-5 for clinical use.

In effect, the amendment of L-233 cancels all ratings for the purchase of film, including those outstanding, which have not been assigned through one of the specified forms. In particular, ratings that have been procured under CMP regulations 5 and 5A are no longer valid for the purchase of film.

The action was necessary to re-establish equitable distribution of film. As a result of the definition of film as "operating supplies" in CMP regulations 5 and 5A, commercial, governmental and institutional users of film were automatically assigned AA-2X, AA-1 and A-10 ratings on a blanket basis for procurement of their supplies.

CONSTRUCTION APPLICATIONS MUST GO TO WASHINGTON

WASHINGTON, D. C.—Hospital construction applications to the War Production Board are all submitted to Washington and cannot be approved by the regional offices as stated in The MODERN HOSPITAL last month. They are considered national in character, according to Everett W. Jones, head hospital consultant, and so must be approved on a national basis.

Gas Cleansing Station in Every 150 Bed Hospital, O.C.D. Urges

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—Special instructions to hospital administrators were noted on an operations letter sent out from O.C.D. April 8 in regard to gas cleansing stations. The letter defines the application of the terms "decontamination" and "gas cleansing," the primary purpose of gas cleansing stations, their location, how they should be established, who should plan them and how, their capacity and the individuals responsible for their development.

The seven specific instructions are as follows:

1. It is recommended that the term "decontamination" be reserved for areas and objects and that hereafter the removal of vesicant liquids from persons be termed "gas cleansing." The facilities established for this purpose will be called "gas cleansing stations."

2. The primary purpose of these facilities is to protect hospitals and casualty stations and their staffs and patients from contamination by injured persons who have been exposed to vesicant agents. Contaminated persons who are not disabled are expected to cleanse themselves in near-by private homes.

3. In large cities in the target areas, it is recommended that cleansing stations be provided at or adjacent to hospitals in the ratio of one station for 50,000 inhabitants. A station should be provided at every hospital that has 150 beds or more and, if this does not bring the number up to the recommended ratio, additional stations should be established at smaller hospitals or casualty stations. At least one station should be established in every city of 25,000 or more in the target areas.

4. Construction of new facilities is generally not justified. Cleansing stations should be established by conversion of sufficient existing facilities.

5. The chief of Emergency Medical Service and senior gas officer should assist hospital superintendents in planning their cleansing facilities. In hospitals the facilities that should prove suitable for conversion to cleansing stations are, roughly in the order of preference, hydrotherapy rooms, nurses' or interns' locker and shower rooms, part of the out-patient department, garages or other separate structures. Each large community should establish without delay at least one gas cleansing station for training purposes.

6. Cleansing stations should be equipped to take care of from one third to one half of the hourly casualty receiving capacity of the hospital to be served. The professional staff will consist of mobile medical teams assigned when the station is activated, supplemented by an additional staff of attendants.

7. The local chief of Emergency Medical Service is responsible for the development of these stations, with the senior gas officer as his consultant.

If You Must Have New Sterilizer, Here Is the Way to Obtain It

By EVERETT W. JONES
Head Hospital Consultant
Governmental Division, W.P.B.

WASHINGTON, D. C.—Prolonged delays have unavoidably occurred in deliveries of sterilizers to civilian hospitals.

A measure of relief is now in sight. The Safety and Technical Equipment Division, W.P.B., has placed all manufacture and delivery of sterilizers under scheduling control to ensure that the available civilian quota each month goes where it is most needed.

Our section will cooperate by listing institutions to which deliveries will be made in order of urgency.

Existing preference ratings are of little value in making up this list. In many cases these ratings are hopelessly obsolete. Hence, no new preference ratings or increases of former ratings will be granted.

Hospitals in real need of essential sterilizers are requested to furnish immediately to the Hospital Section, Governmental Division, W.P.B., Washington, D. C., the following data:

If you are constructing a new hospital or making an addition to an old one, give:

1. Sterilizers already authorized for project, including name of manufacturer and size and description of each piece.

2. On what form or forms such authorization was granted, the W.P.B. serial number assigned and the rating granted to the sterilizer application, not the construction job.

3. Date when your order, with above rating, was placed with manufacturer.

4. Date authorized construction on project actually started.

5. Present stage of construction (in per cent of completion).

6. Date new facility is actually expected to open.

If you want a new sterilizer as replacement or for any other reason, give answers to items 1, 2 and 3 above and in addition:

4. Concise and objective statement of conditions today in your hospital that make your need urgent.

Remember you are not pleading to a jury. You are furnishing your government with essential information.

Medical Equipment and Supplies Lose AA-1 Rating Under New Rule

WASHINGTON, D. C.—C.M.P. 5A was amended on May 15 to exclude medical, surgical and dental instruments, equipment and supplies. It does not exclude parts for maintenance and repair of these items. Thus, hospitals cannot apply an automatic AA-1 rating to the purchase of the excluded items.

In theory, at least, under C.M.P. enough material is allotted to fill orders for these items without ratings. If hospitals find that they cannot obtain such items without ratings, they can file the appropriate application form (usually PD-1A) with the Governmental Bureau, W.P.B., Washington.

Another new arrangement allows PD-1A hospital applications up to $500 value to be processed in the nearest regional or district W.P.B. office.

The list of excluded items is as follows: (a) anesthesia and oxygen equipment and accessories, (b) atomizers, (c) clinical thermometers, (d) crutches, (e) dental consumable supplies, (f) dental equipment and appliances, (g) diagnostic instruments and apparatus, (h) electric light bulbs for diagnostic instruments, (i) hearing aids, (j) hospital and medical rubber drug sundries, (k) hospital enamelware and stainless steel ware, (l) hypodermic needles and syringes, (m) medicinal preparations, including vitamins, (n) operating and examining room furniture, (o) operating and examining room lights, (p) ophthalmic goods, (q) orthopedic appliances, including splints, belts and trusses, (r) physical therapy apparatus, (s) sterilizers, (t) surgical dressings, (u) suture needles, (v) sutures and (w) x-ray equipment and supplies.

O.D.H.W.S. Changes Name

WASHINGTON, D. C.—The Office of Defense Health and Welfare Services has been renamed the Office of Community War Services. Charles P. Taft becomes director of Community War Services under Federal Security Administrator Paul V. McNutt.

W.M.C. Establishes Nursing Unit With Alma C. Haupt as Chief

WASHINGTON, D. C.—The long awaited nursing unit in the War Manpower Commission has been established, according to an announcement by Chairman Paul V. McNutt on May 17. Alma C. Haupt has been named as chief, with Louise Baker of San Francisco as associate chief of this Nursing Supply and Distribution Unit.

The new unit is designed to effect an equitable distribution of graduate nurses for military, governmental and essential civilian needs, somewhat as does the Procurement and Assignment Service for physicians.

Establishment of the unit was requested by the National Nursing Council for War Service and the subcommittees on nursing and hospitals of the Health and Medical Committee of the F.S.A.

State and local councils for war service will be utilized for the operation of the unit. Quotas will be set up on national and state bases for the guidance of nurses in accepting service in military, governmental and essential civilian service. It is expected that this will aid both nurses and hospitals to obtain an orderly withdrawal of nurses from civilian activities.

A seven member advisory committee to the new unit has been set up under the chairmanship of Katharine Tucker, director of the department of nursing education of the University of Pennsylvania. Dr. Claude W. Munger is the representative of hospitals.

Liaison members include the National Nursing Council for War Service, Red Cross, Army, Navy, Veterans' Administration, Public Health Service, Children's Bureau, Office of Indian Affairs, Office of Civilian Defense and Civil Service Commission.

Two Texas Hospitals Build "Victory Villages" for Nurses

Prefabricated huts are being used at Methodist Hospital, Dallas, Tex., to solve a serious housing shortage created by the imminent arrival of a new class of nursing students.

Although the hospital had been granted priorities to build a much needed nurses' home, plans were abandoned when it became impossible to obtain building materials. The situation was temporarily relieved by the purchase of several cottages near the institution, but they did not give sufficient accommodation for the incoming class of nurses.

Early in the spring, therefore, the late Rev. J. H. Groseclose, administrator of the hospital, whose death on May 9 from a heart ailment is reported elsewhere in this issue, investigated the possibilities of prefabricated housing. Within a few weeks, 12 "Victory Huts," each 16 by 16 feet in size, were delivered to the hospital to be erected in a v-shape formation in a grove on the hospital grounds.

This Victory Village, housing 30 nurses, will be completed in time for the June 1 class at an over-all cost of less than $10,000.

Another Texas institution that has turned to prefabricated huts as a solution to the housing situation is the Dallas City-County Hospital System. Senior nurses are now living in Victory Huts on the grounds at Parkland, according to Supt. Russell C. Nye.

U. S., Canada Arrange Reciprocal Medical Care Plan for Armed Forces

WASHINGTON, D. C.—Under the terms of a reciprocity arrangement between the United States and Canada, personnel of the United States armed forces while on duty, leave or furlough in Canada who cannot reasonably obtain medical or dental treatment from the United States facilities in Canada will receive free treatment for immediate requirements by Canadian medical and dental services. If the treatment or hospitalization exceeds thirty days, arrangements will be made for transfer, when possible, to the United States.

Canadians in this country requiring immediate medical or dental treatment will report to the nearest U. S. Naval or Army Hospital, to the nearest veterans' hospital or to the nearest medical representative of the Veterans' Administration. If none of these facilities is available, Canadian personnel will be admitted to civilian hospitals. The Canadian Legation will be notified and bills for treatment will be forwarded to the surgeon general of the U. S. Army.

Kirk Named to Succeed Magee

WASHINGTON, D. C.—On May 3 the President sent to the Senate the nomination of Brig.-Gen. Norman Thomas Kirk to be the surgeon general of the Army with the rank of Major General. He succeeds Maj.-Gen. James C. Magee whose four year term as surgeon general of the Army expires June 1. Prior to his appointment, General Kirk was commanding officer of the Percy Jones General Hospital, Battle Creek, Mich. It has not yet been announced whether General Magee will retire from the service or take some other active part in the war effort.

Some Telephones Available

WASHINGTON, D. C.—A substantial stock of telephone sets is still in existence, according to information received by Everett W. Jones, April 19, in answer to persistent inquiry on his part. Under certain conditions in certain types of hospitals, telephone intercommunications between dietary department serving stations and nursing floors are absolutely essential to the operation of the hospital, Mr. Jones had pointed out to the appropriate division of W.P.B. Full consideration will be given, an official assured Mr. Jones, for essential requirements for communication equipment. The manufacture of these sets is restricted by order L-204.

Relief on Food Problems Forecast by Palmer at Tri-State Assembly

With a galaxy of federal officials present to advise hospitals on the latest requests and rulings, the Tri-State Hospital Assembly, May 5 to 7, attracted an attendance of more than 5000, according to the chairman, Dr. Malcolm T. MacEachern, and held its most successful meeting.

A unique feature of the session was that representatives of the Office of Civilian Defense appeared before each of the 30 different groups making up the Tri-State. Dr. John S. Coulter, Dr. Jack Masur, Dr. Lloyd H. Gaston and Dr. Victor Vogel made most of these presentations, outlining for each group how it can cooperate in civilian defense.

The three morning general assemblies were devoted, respectively, to food rationing, supplies and priorities and personnel. Archie Palmer, deputy administrator in charge of institutional users, food division, O.P.A., was the star speaker on the first general assembly. He expressed a sympathetic attitude to hospitals and declared that O.P.A. would soon announce changes that would solve from 90 to 95 per cent of hospital rationing problems. The remaining difficulties, he declared, pertain to persons whose dietary problems result from the nature of their disease.

In spite of the administrative difficulties presented by rationing, priorities, manpower shortages and other acute problems, this is the time for hospital administrators to rise above these problems and to make basic improvements in hospital service, Dr. R. C. Buerki, former chairman of the Tri-State Assembly, declared. He suggested, as examples, improvements in medical staff organization, trustee relations and public education activities.

The O.C.D. Bulletin No. 3 on "Protection of Hospitals," which was published in the February 1942 issue of The Modern Hospital, is now being revised, stated Dr. Jack Masur. He also announced a new civilian war security program.

Federal funds for grants to hospitals to set up plasma banks have been practically exhausted, according to Dr. Victor H. Vogel. There are now about 150,000 units of plasma in reserve in all parts of the country for use in emergencies resulting from enemy action. If plasma is needed for disaster use, Doctor Vogel urged hospital administrators to ask the local chief of E.M.S. for it.

Doctor Vogel announced that authority had been granted on May 4 to purchase four-stretcher ambulance bodies to supplement the present sketchy ambulance equipment. These bodies can be put on used 1939, 1940 or 1941 model Fords, Plymouths or Chevrolets. The federal government will provide a limited number of bodies and local groups will be expected to provide the chassis and mountings. Most of them will be allocated to the coastal areas but about 60 should be available for the four states in the Tri-State Assembly.

Important developments ahead for Blue Cross plans were visualized by both C. Rufus Rorem and John Mannix. These include: simplification of Blue Cross office routines to reduce administrative cost, adjustment of payments to hospitals to reflect actual costs, establishment of national enrollment offices in New York City, Chicago, Pittsburgh and on the West Coast, extension of plans to the 13 states now without plans, consolidation of plans into state-wide or regional groups, the offering of really comprehensive service by all plans, great extension of rural enrollment and making plans available to small groups.

NEW STATE OFFICERS

Illinois Hospital Association

President, Frank W. Hoover, Decatur and Macon County Hospital, Decatur.
First Vice President, Vernon T. Root, Rockford Memorial Hospital, Rockford.
Second Vice President, Sister M. Marcelline, St. Mary's Hospital, Galesburg.
Secretary-Treasurer, Victor S. Lindberg, Victory Memorial Hospital, Waukegan.
Trustee, F. Jane Graves, Alton Memorial Hospital, Alton.

Indiana Hospital Association

President-Elect, Sister Mary Reginald, Mount Mercy Sanitarium, Dyer.
President, Frank G. Sheffler, Union Hospital, Terre Haute.
Vice President, Dr. Charles W. Myers, City Hospital, Indianapolis.
Trustees, Hannah Rosser, Vermillion County Hospital, Clinton, and Daisy Craver, Clinton County Hospital, Frankfort.

Michigan Hospital Association

President-Elect, Dr. Leverett S. Woodworth, Harper Hospital, Detroit.
President, Dr. L. V. Ragsdale, Butterworth Hospital, Grand Rapids.
First Vice President, J. A. Blaha, Grand View Hospital, Ironwood.
Second Vice President, Macie Knapp, Memorial Hospital, Owosso.
Secretary, Robert G. Greve, University Hospital, Ann Arbor.
Trustees, Dr. John H. Law, Grace Hospital, Detroit, and Amy Beers, Hackley Hospital, Muskegon.

Army Air Forces Need 3000 Additional Nurses, A.A.F. Spokesman States

Washington, D. C.—The Army Air Forces need approximately 3000 additional nurses, declared a spokesman for the A.A.F. on May 11. This particular service offers numerous opportunities to qualified nurses.

Although the general duties of a nurse in a military hospital are similar to those performed in civilian hospitals, including night duty, an effort is made to assign nurses in accordance with any special abilities they possess, to provide them wherever possible with particular types of training desired and otherwise to coordinate military needs with personal desires to the fullest extent possible.

Nurses serving with the Army Air Forces are assigned to air fields in the continental limits of the United States, overseas duty, air evacuation units and similar aviation medical installations. Those who go overseas will be selected largely on a volunteer basis. First station assignments will be in the United States.

Applicants for duty assignment with the Army Air Forces should write to the Office of the Air Surgeon, Headquarters of the Army Air Forces, Washington, D. C., or file an application marked "AIR" with a Red Cross nurse recruiting station.

Byrnes Issues Clarification of "Hold-the-Line" Order

Washington, D. C.—Of interest to workers in the hospital field and other essential activities was the further definition of Director of Economic Stabilization James F. Byrnes on May 12 of the President's "hold-the-line" order.

The National War Labor Board had issued a joint statement May 7, declaring that the executive order was unworkable without further clarification.

The policy directive of Mr. Byrnes clarified and defined the basis for the War Labor Board in making wage adjustments under the "Hold-the-Line Order."

In summary the directive: (a) reaffirms the Little Steel formula; (b) makes clear the authority of the board to make wage adjustments under the authority contained in the order provided such adjustments are *within the existing price structure and within existing levels of production* costs, and (c) makes clear that any wage adjustments that may furnish the basis either to increase price ceilings or increase production costs cannot become effective until approved by the director.

LOOKING FORWARD

Student War Nursing Reserve

NURSING, hospital, public health and military leaders have rallied to the support of the bills introduced in Congress by Mrs. Frances P. Bolton and Sen. Josiah W. Bailey to provide a Student War Nursing Reserve. The purpose of the measures is not only to increase the federal financial aid to nursing schools and to student nurses but also to lend the moral support and prestige of federal service.

Hospital administrators and nurses have suggested the desirability of amending the bills to provide for a time limit on the present program and also for an advisory board including hospital administrators. These have been included in the bill that passed the house.

The nation-wide nurse recruitment campaign, described in the April issue by Florence M. Seder, has thrown a heavy burden of clerical work on the National Nursing Council for War Service and on its state and local branches. So far, the funds for this council's work have come largely from nurses and from the Kellogg Foundation. There is some feeling that the hospitals are the principal beneficiaries of the council's activities and that the nursing profession, in fact, may be multiplying its future problems through entrance into the profession of a large number of "accelerated" nurses. It is unfortunate that the council did not come to the hospitals in the very beginning and enlist their full cooperation and participation and their financial assistance.

It is not too late, however. The president of the American Hospital Association has been invited to sit in on deliberations of the National Nursing Council and the hospitals have four representatives on a joint committee with the nurses. If they find a wholehearted spirit of cooperation, they will doubtless recommend that hospitals warmly support the work at the national, state and local levels.

Health in the Postwar World

AS REPORTED in our April issue, warnings of serious increases in disease in various parts of the world were voiced by several of the speakers at the National Conference on Planning for War and Post War Medical Services. Many of the papers from this conference have been published in the *Journal of the American Medical Association* for May 1. They constitute "must" reading for the hospital administrator who sees beyond the narrow walls of his own institution and his own community.

Among the tropical diseases which Lt.-Col. Thomas T. Mackie fears will constitute serious problems are malaria, plague, cholera, typhus, the dysenteries, leishmaniasis, trypanosomiasis and a host of others. The tremendous development in air transport between widely separated sections of the world provides an obvious means for the translation of disease to new areas. Dr. Thomas Francis pointed out that strayed parasites of influenza would find conditions for dissemination highly satisfactory. And with all these possibilities, President E. C. Elliott of Purdue University predicted a postwar shortage of physicians.

The New York Academy of Medicine recently appointed a committee to study changes in economic and social organization and their effect on the practice of medicine. There are at least three groups in Washington that wish to undertake the task of planning the postwar hospital system.

It is obvious that the time has now arrived to begin to take thought for the morrow. The American Hospital Association has authorized a national commission on hospital service but actual appointment of the commission and inauguration of the study have been held up while funds are sought. Let us hope that the delay will not be too great.

Time for Offense

DEFENSE, no matter how brilliant, does not win wars. Eventually it must be replaced by offense. This is true in social fields as well as in the purely military sphere.

Voluntary hospitals and voluntary Blue Cross plans cannot hope to win their battle against those who wish to submerge them in a completely governmental system by defensive measures alone. They must take the offensive, not against the people who are arguing for a governmental system but against the problems that still need to be faced.

The Blue Cross plans are realizing this necessity. At their 1942 meeting in Philadelphia, at the session in St. Louis last fall and again at the midwinter meeting in Chicago in February they have hammered out at least the first elements in an offensive campaign. This is based upon the premise that 100,000,000 or more Americans should have Blue Cross protection. A variety of steps toward this objective is being taken now and others are contemplated for the immediate future.

While the strengthening of Blue Cross plans will automatically result in considerable improvement in the position of voluntary hospitals, this is not enough. There are many things that the voluntary hospitals and the various citizen groups that stand back of them should do themselves. Next month an important policy statement on this matter will be presented by two members of The Modern Hospital staff.

In the eight years from 1934 to 1942, the number of voluntary hospitals increased by 280 and their beds increased by nearly 49,000. But during this same period, governmental hospitals of all types increased by 175 and added nearly 298,000 beds. Thus, beds in governmental hospitals increased six times as fast as those in voluntary hospitals. True, many of these beds were for nervous and mental disease hospitals or for the Army. But the 1244 governmental general and special hospitals now have 305,600 beds as compared with only 295,000 beds in the 2770 general and special hospitals under voluntary control. The various units of government have already passed the voluntary hospitals.

While some of the Army's hospitals are temporary and will doubtless be torn down or reconverted after the war, it is clear that voluntary hospitals must step forward rapidly if they are to maintain their position of leadership.

Hospital Ethics

THE American College of Hospital Administrators has been notified that St. Luke's Hospital, Chicago, by formal action of its board of trustees, has adopted the code of ethics developed jointly by the college and the American Hospital Association. This is newsworthy because it is the first hospital that has notified the college that it is making the code a definite part of its own rules and regulations.

At the St. Louis meeting of the college last fall it was voted that copies of the code be sent to all members and fellows of the college with the suggestion that they present it to their trustees for adoption. This has now been done and undoubtedly during the coming months many other hospitals will adopt the code in full or in part.

The college has not set up any machinery for interpreting or enforcing the code among its membership. For the present, at least, it is relying entirely upon voluntary cooperation. In case of flagrant violation, the executive committee and regents would have to decide what action should be taken. No such cases have yet presented themselves. It has been suggested that the joint committee that drafted the code might be continued permanently but no action has yet been taken on this proposal.

Money Here and Now

THE year 1943 is probably the best since 1929 in which to raise large funds for hospitals. This is no surmise—it's a fact.

The annual campaign of the United Hospital Fund of New York was well ahead of last year's total. During the last ten years, the fund has more than doubled its annual goal.

In recent hospital campaigns millions of dollars have been given by individuals in stocks and bonds. Without belittling their generosity, it may be pointed out that such contributions so favor the taxpayer that the net cost of gifts is often near zero.

Corporations, too, find the tax situation helpful when asked to give funds required for hospital modernization and expansion. This fact is indicated by the gifts to Hartford Hospital, Hartford, Conn., of $200,000 by the United Aircraft Corporation, of $185,250 by the Colt Patent Firearms Manufacturing Company and of $106,000 by the Niles-Bemont-Pond Company.

In many instances, people and corporations are giving money to build hospitals that will not even be started until the end of the war. By so doing they are investing in America's future just as much as though they bought additional war bonds. Indeed, some are giving war bonds or the hospitals are investing the money in war bonds.

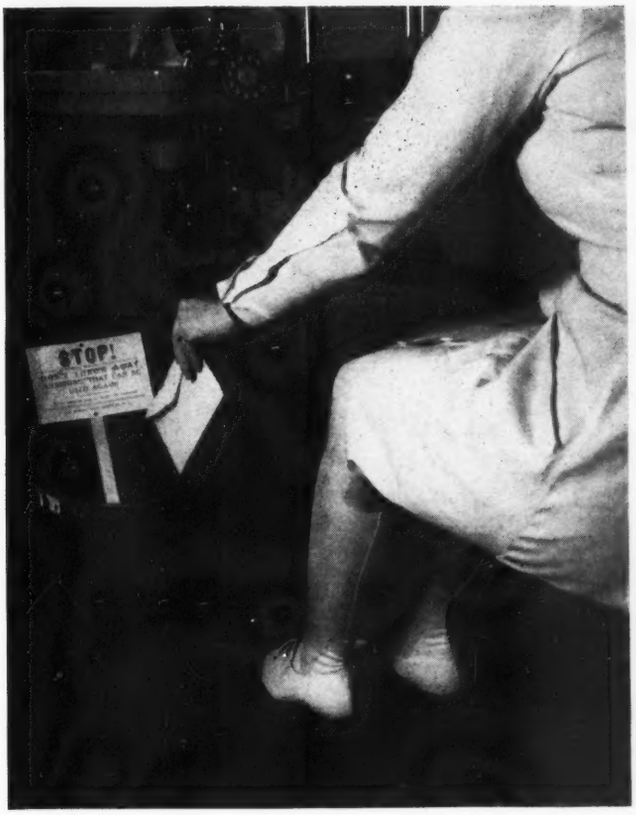
If, after the fall of Berlin and Tokyo, our hometown voluntary hospitals have the physical capacity to rehabilitate disabled soldiers and sailors, it may prove practical to ask the federal government to use their facilities at a cost rate. The ultimate cost to taxpayers would probably be considerably reduced and the lads would be in their own hometowns so that they could keep in close touch with their families and friends and with their regular physicians.

Watch Your Step

NOW that supplies and equipment are scarce, there is a great temptation—often a real need—for hospitals to buy wherever they can find commodities. It is reported that there is an increase in offerings to hospitals by fly-by-night concerns that attempt to pawn off rejects, seconds or other defective goods as being of first quality. The safest defense against such sharp practices is for hospitals to continue to deal as much as possible with firms that have a long reputation for probity and fair practice. When such firms offer goods that are not up to the usual quality, as they may have to do during the war emergency, they will tell hospitals frankly just what the shortcomings are.

WASTE NOT WANT NOT

A Study in Conservation



MAXWELL S. FRANK, M.D.
ASSISTANT DIRECTOR, MOUNT SINAI HOSPITAL, NEW YORK CITY

NOW more than ever before hospital administrators are called upon to exert their ingenuity in order to conserve supplies and equipment. This is a matter not only of economy but of stern necessity. Because of the interest of those who are responsible for hospital management in exploring every possible method for economy, the experience of Mount Sinai Hospital, New York City, is described here in some detail. No originality is claimed for any of these conservation measures, but a résumé may be helpful to the reader who finds even a solitary practical suggestion.

The devising of economy measures is of little value unless all the personnel of an institution is imbued with the doctrine of conservation and is taught and regularly reminded of economy practices. To nurture an "economy conscience" the message of conservation is brought home forcefully and continually to professional staff, lay personnel and volunteer workers. Supplementing the vast government publicity on the subject, the message of "Waste Not, Want Not" is brought home in talks with department heads, in memorandums to them, in signs and posters in every appropriate place.

One effective device is a card with the slogan "Waste Is Sabotage" in bold red type. This message with its patriotic appeal is posted by the hundreds throughout the hospital. Similar cards, tacked to sticks, are placed in wastebaskets. Government posters on the same subject are also used freely.

See Page 100 for a continuation of this article on conservation in the food service department

The admonition "Think Twice Before Ordering" is repeatedly emphasized. The monthly departmental reports of professional service are constantly checked, and department and clinical heads are requested to explain and reduce the use of items that seem excessive and to extend their efforts by greater care in ordering. Current departmental supplies are ordered by means of weekly requisitions on the storeroom. Every requisition form carries this message:

Order ONLY What Is Actually Needed, Do Not Hoard Supplies

All requisitions must first be reviewed and approved by the department heads before being submitted to the purchasing office for final scrutiny and approval. Careful investigation of the need for each item requested, based on detailed knowledge of the department's practices and the requirements of patient loads, determines the quantities that are approved for issue by the storeroom.

Casual or excessive requisitions are returned to department heads for complete (and convincing) explanation. Suggestions for additional economies are solicited at frequent intervals from the heads of departments and from the employes; some quite worth-while ideas have come to our attention in this manner.

Shortages or impending shortages of supplies are brought to the attention of the employes, and their active cooperation is sought in limiting their requests for those items to the minimum required for essential needs. Replacements of durable supplies are not issued unless the worn-out items are returned for exchange; this fixes responsibility for losses or transfers.

The hospital sells its scrap paper and cardboard, old rubber (including rubber gloves and catheters), steel drums (these are now returnable for credit), burlap bags, empty barrels, bottles and jugs, egg crates, discarded flower baskets, tin cans, fats, grease, bones, garbage and swill. Unsalable scrap is donated to the various salvage drives.

General Economies

As a result of careful analysis of all requisitions on the hospital storeroom, reductions in the weekly orders, before approval for issuance,

average approximately 10 per cent. Department heads must explain satisfactorily any questionable items. The practice of requiring exchanges for nonperishable items is followed extensively. Emphasis is placed on the desirability of having too little on the wards and floors rather than too much. An occasional midweek requisition is approved when necessary. No privation is imposed upon any patient, for if an item is really needed and available it is issued. Thus, in the final analysis, the quantity of any item dispensed is dependent upon the administrator's first-hand knowledge of the requirements of the department.

Nursing Service

Rounds: Nursing shortages have been relieved in part by a reduction in the proportion of nursing service on rounds. These are made by ward nurses twice a day or, at the most, three times daily. The attending physician in charge of the service specifies the frequency of these rounds.

Temperatures: Temperature, pulse and respiration are now taken once daily for ambulant cases, twice daily for the ordinary bed cases and every four hours as ordered on special cases.

Doctors' Orders: Certain standing orders have been reduced, particularly those with reference to charting and recording fluid intake and output. Nurses no longer write out orders by attending and house staffs. Instead of dictating these orders to the nurse, the staff now writes them directly.

Treatments: Preliminary enemas are not administered when colonic irrigations are ordered, unless an enema is ordered specifically to precede colonic irrigations.

Rehfuss tests are done only in special cases, *i.e.* those under study because of surgical features.

The Janney and the galactose tolerance tests are not performed except in selected cases.

The urine concentration test is not ordered if the specific gravity of a single specimen is 1025 or greater.

The nurse's responsibility for intravenous medication is limited to the setup; she need not assist the doctor unless the patient is acutely ill.

Simple and nontechnical nursing duties have been transferred to volunteer nurses' aides.

Baths: The time of giving baths to patients has been staggered. All are not given during the morning, but the total number of baths has not been reduced.

Nourishments: The doctor's order determines whether a patient is to receive extra nourishments.

Reviews of Procedures: All nursing procedures are reviewed periodically for simplification.

Gauze and Bandages

It has been found possible, to the complete satisfaction of the staff and with safety to the patient, to use gauze and bandages in smaller sizes. A 12 by 16 inch cotton-filled gauze pad is frequently used instead of the 10 by 24 inch size.

An 8 by 8 inch pad satisfactorily replaces the 8 by 10 inch size in many cases.

Twelve inch by 10 yard cut adhesive is issued in individual cuts; only the larger departments, such as the out-patient clinic, receive full cans.

Twelve inch by 5 yard crinoline-backed adhesive is now dispensed in half rolls, 12 inches by 2½ yards.

No cut adhesive wider than 3 inches is used.

In the operating rooms mastoid dressings are used in 8 inch lengths and iodoform dressings in 15 inch pieces.

Stationery and Printing

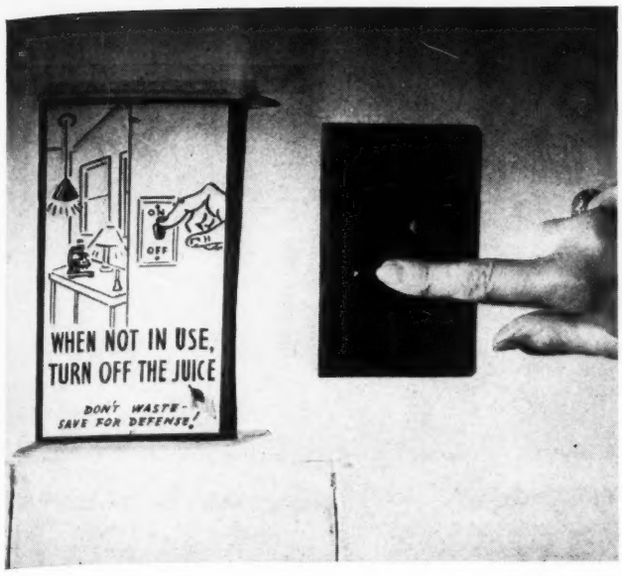
It has been found possible to effect perhaps the greatest economies in the use of stationery and printing supplies. Rubber bands are dispensed to nonclinical departments in packages of 12. All departments that use surgeons' rubber gloves receive no rubber bands. They prepare their own by cutting up old rubber gloves that are beyond further use or repair. Except for the larger units, out-patient, social service and accounting departments, the divisions of the hospital receive three or fewer pencils weekly.

Ink is not issued unless the empty deposit bottles are returned. When ink has been permitted to evaporate in the wells, instructions have been issued to restore it by the addition of water to the sediment. Not more than three or six pen points per order are dispensed. Only one carton of paper drinking cups is dispensed on an order, except in certain areas, such as the emergency room and blood bank. The use of drinking glasses for the permanent personnel is encouraged. Only one fourth box of paper clips is issued.

Paper is used with great care and little is discarded. Scratch pads for general distribution are made by the occupational therapy department from old paper that has been used on one side only. (This procedure requires merely a glue pot, brush and cheap gauze backing.)

Incoming envelopes are opened, whenever possible, along their sealed flaps and are utilized for internal mail throughout the hospital, all envelopes being used repeatedly in this internal distribution by tucking the flaps under instead of sealing them. Each sender crosses out his name and writes in the name of the next recipient. Even the attending physicians' room contains a basket near the mail boxes, with a notice requesting that all envelopes be saved and deposited for possible reuse. In mimeographing short announcements, paper is saved by repeating the text several times on the same stencil and then cutting the imprinted sheets. Wherever possible, mimeographing is done on both sides of the paper. The pharmacy uses inexpensive paper pill-velopes instead of cardboard pill boxes.

Commercial advertising blotters received by the hospital and its personnel are used, and surplus blotters are sent to the storeroom for general distribution. Wastebaskets are lined with newspaper. Straw drinking tubes are provided only where there are specific indications for their use; in other cases they have been re-



Such posters as these and the sign in the wastebasket (shown on the preceding page) have proved quite successful at Mount Sinai Hospital, New York, in nurturing an "economy conscience" among employes.

placed by glass tubes which have been found to be more economical. Black and red typewriter ribbons are not ordered when both colors are not needed. All black ribbons are reversed during use so that the upper and lower portions receive equal use. New ribbons are issued only on an exchange basis and the spools are returned to the manufacturer for credit.

Medical and Surgical Supplies

Surgeons' blades are resharpened several times after use. Old razor blades are sharpened by honing in a drinking glass and when they are beyond use are saved in special jars for scrap. Scissors and other instruments in operating rooms are sharpened by an experienced orderly instead of being sent out for commercial sharpening. The pharmacy dispenses alcohol as follows: absolute alcohol is used only in lamps; 70 per cent alcohol is used generally, and waste alcohol from the operating rooms is filtered, colored and reused as rubbing alcohol. Less expensive cresol and bichloride of mercury solutions are used instead of alcohol wherever possible in the operating rooms. These different types of alcohol are distinctively colored to prevent improper use.

The surgeons use silk instead of catgut sutures when this is feasible. Tubes of suture material are opened only as needed or specifically requested and shorter strands are employed. Straight and safety pins (both scarce items) are dispensed from the storeroom in limited quantities to encourage the reuse of those previously distributed.

Sterile solutions of cocaine, novocaine and atropine are prepared in small quantities to prevent waste. Petrolatum, lubricating jelly and other medicaments are issued by the pharmacy only on an exchange basis upon the return of the empty tins. Catheters are carefully handled and exchanged for replacements only when they are beyond use. Rubber glove consumption has been lowered by emphasis upon their proper use and careful patching and reuse. Expensive drugs, *e.g.* sulfa derivatives and heparin, require the written approval of an assistant director on a special prescription blank before they are issued.

Linen

All linen items have been checked from the point of view of supply and demand to eliminate waste and to introduce adequate, less expensive substitutes. Part wool flannel shirts have been replaced by less costly canton flannel. The sizes of the operating room and surgical towels have been reduced 2 inches. Dish towels have been made 2 inches shorter and linen towels have been replaced by part linen. By the addition of a foot of material to the drape sheets used in the operating rooms, the use of an extra throw sheet has been eliminated from laparotomy and dilatation and curettage set-ups. Bed linen is changed less frequently; previously, moderately ill patients received a complete change of linen daily and ambulatory patients somewhat less frequently. At present, linen on the wards is changed as needed.

Postmortem nursing procedure has been changed by the elimination of the use of a draw sheet in postmortem nursing care. Instead, a T-binder, made by the hospital laundry of old flannel, is used. It is not necessary to remove this binder before the body is placed in its paper shroud, thus saving draw sheets which formerly would occasionally leave the hospital with bodies removed by undertakers.

Light, Heat and Power

Placards encouraging the conservation of electric lights and hot water have been posted throughout the hospital, together with notices concerning the proper use of steam radiators and the importance of closing windows when radiators are turned on. Fewer overhead lights are used in the operating rooms during operations; frequently two instead of four when floor lighting is employed.

Gas is saved by not preparing floor kitchens too far in advance of meal service. A reduction by several minutes of the washing formula in the laundry has resulted in a saving of electricity, steam and hot water.

Laboratories

Stock on hand is checked at frequent intervals for control. Only the most important specimens are preserved by the pathology laboratory, with a resulting saving of formalin, glycerin and alcohol. Also, photography of important specimens has made it unnecessary to preserve many of them. Plastic cover slips have been substituted for the expensive glass slips. Rubber gloves worn in the necropsy room are protected by canvas gloves.

Chemistry and bacteriology routine examinations have been reduced through the cooperation of the attending staff, which requests only laboratory examinations that are considered indispensable for the diagnosis or treatment of the patients.

Hospital-owned radium is used wherever possible instead of radon. Shorter strips of electrocardiographs are taken, which also results in the saving of mounting tissue and other supplies.

Some of the measures described are of an emergency character and need not be continued after the war. Other economy practices that have been put into effect will be of lasting benefit and the economy-mindedness that has been developed will be a permanent asset to the hospital.

What's the Future of

It's a Federal Problem

I. S. FALK

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THE goal of the social security program is the development of a comprehensive and unified system of social security that would furnish basic social and economic protection to the people of this country against all the major common risks against which individuals and families cannot protect themselves.

The outlines of a possible hospital insurance system that have begun to take shape are, in part, the results of studies by the Social Security Board and, in part, the results of conferences with committees of the hospital associations and with various experts in hospital administration.

Unified System Would Be Basis

The first premise is the assumption that hospitalization benefits would be provided through a unified system of social insurance. Under the present system, more than 45,000,000 workers paid some contributions in 1942, although not all paid enough to be currently insured. If the coverage of the system were expanded as recommended by the Social Security Board and came into operation in 1944, from 40,000,000 to 50,000,000 workers would be protected the next year. The insurance protection should extend not only to the insured workers but also to their dependents and perhaps also to the annuitants of the insurance system. Thus, the system might insure against hospital costs between 80,000,000 and 110,000,000 persons, depending upon the coverage and various details.

The hospitalization benefits would be those that could be financed, over a period of years, by the average annual yield of 1 per cent of taxable pay rolls or earnings, paid as part of a single contribution for the entire insurance system.

One per cent of pay roll will probably yield approximately $600,000,000 in 1943 with the present coverage; with the expanded coverage recommended it would probably yield about $800,000,000 this year. Over a number of years and allowing for ups and downs in the labor market and in earnings levels, a contribution rate of 1 per cent for the enlarged coverage would be equivalent to *at least* $600,000,000 a year. If high levels of employment and wages persist, the amounts available for annual disbursements could be considerably more.

An expanded social insurance system could guarantee payments of an annual sum at least equal to, and probably substantially greater than, the total income of the general hospitals of the country in a recent depression year and probably as much as, or more than, their total income now.

In a unified insurance system only a small fraction of the contribution for hospital benefits would need to be used for administration costs—probably not more than 5 per cent of the benefit disbursements and perhaps less. A contingency fund could assure the continuity of income to the hospitals during ups and downs of a business cycle.

The Social Security Board has recognized from the beginning of its studies that the hospitalization insurance benefit could take the form of a cash payment to the insured person, a reimbursement benefit; or it could take the form of a service benefit, the insured person receiving the service and the institution that furnishes the service receiving direct reimbursement from the insurance system.

A cash benefit, to be practical, might have to be a nationally uniform amount for each day of hospitalization. It probably would have to be a minimal cash benefit in order not to exceed the per diem charge for hospital care in areas and in institutions in which the charges are relatively low.

A service benefit could take the form of a guarantee to the insured person that he will receive all essential services and that the hospital will receive a fair reimbursement, but not necessarily a nationally uniform amount.

What Are Merits, Drawbacks?

There are advantages and disadvantages to each type of benefit.

To the social insurance administrator, the cash benefit has the advantage that it involves only the direct payment of a check to the insured person; it has the disadvantage that many millions of claims would have to be adjudicated and many millions of checks sent out each year. To the public, the cash benefit has the advantage that the insured person would know precisely the amount to be received as a benefit for each day of hospitalization, but it has the disadvantage that such a fixed benefit amount, particularly if it is a minimal amount, gives no guarantee that the benefit will be sufficient to pay the actual charges of the hospital.

To the hospital, the cash benefit has the advantage that the institution has obligations only to furnish service and to give the hospitalized patient a receipt or other record showing for how many days he had been hospitalized, but it has the disadvantage that it may not be sufficient to enable many of the patients to pay their actual hospital bills. Also, it has been said that some patients might be reluctant to pay the hospital an amount larger than the amount received as insurance benefit.

A service benefit, assuring at least

(*Continued on page* 60)

Based upon an address delivered before the New England Hospital Assembly, Boston, March 1943.

Hospital Insurance?

It Must Be Voluntary

E. A. VAN STEENWYK

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AS A PART of the debate on voluntary *versus* compulsory hospital insurance, certain phrases and arguments have been used so frequently and for so long that they need reexamination. Some, while once true or nearly true, no longer reflect the current situation. Proponents of compulsory insurance have said, for instance, that Blue Cross is all right as far as it goes but that it doesn't go far enough; that adding this service to the administrative set-up of the Social Security Board now would result in certain administrative economies; that the money derived from such a scheme is needed by hospitals.

Five years ago Blue Cross could have been dismissed as not going far enough. But in 1942 hospitals received $50,000,000 from plans for the care of the 11,000,000 subscribers. Administrative economies and simplicity are desirable, but this alone is not enough reason for a major decision affecting public policy. In addition, there is a reasonable doubt that a federal program can in the long run be administered more economically than can Blue Cross plans.

It is true that hospitals need money, but will a compulsory insurance plan provide additional funds? The present income to registered general and special hospitals, excluding federal hospitals, is estimated at about $500,000,000. Approximately 62 per cent of this income comes from patients and 25 per cent from local and federal taxes. The remaining 13 per cent comes from gifts and voluntary subscriptions. What part of this income will be available to hospitals after compulsory insurance is in effect? The $600,000,000 return which Doctor Falk estimates from a 1 per cent tax is to be used not for the general support of hospitals but for the payment of the hospital bills of 90,000,000 insured persons.

Reexamination of former phrases and arguments used against the government scheme is also in order. It has been said, for instance, that whatever government does is done badly; that compulsory hospital insurance will result in the socialization of medicine; that if a cash allowance is provided all the disadvantages of a cash payment plan are increased by the necessity for a minimum payment level on a nation-wide basis; that if a service contract is provided hospitals will find that government has entered the hospital tent and become active in management.

If it were true that everything that the government does is done badly, how can we account for those government services now being performed efficiently and economically? The argument on socialization is usually countered by reference to the fact that for the medically needy private medicine has already been abandoned. As opposed to the argument that a cash payment is inadequate, it has been said that the federal government might offer a service contract. As opposed to the argument that the government might demand a greater share in management of hospitals, it has been pointed out that the same fear was expressed about Blue Cross plans ten years ago.

On the basis of present needs and the practicality of a com-

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HOSPITAL CARE FOR THE AMERICAN PEOPLE
(A.H.A. program adopted October 1942)

1. The immediate establishment by each Blue Cross plan of low cost contracts for service in minimum-rate hospital accommodations.

2. Cooperation in the development in each community of nonprofit plans for medical service for hospital cases, sponsored by the medical profession, similar to those now actively conducted and proposed in many states and communities.

3. The encouragement of local government payments to hospitals for service to "needy" persons whose individual or combined payments are less than the costs of necessary service.

4. Encouragement to the federal government to provide financial assistance, through states, to enable community hospitals to furnish hospital care for federal and state public assistance beneficiaries, including the aged, the blind, dependent children and those on general relief.

5. The encouragement of federal grants for improvement and expansion of voluntary hospital facilities in defense areas and other communities where economic conditions and unusual health needs require such assistance.

6. The recommendation to the United States Congress that, in view of the present rapid growth of voluntary hospital service plans, it defer consideration of the inclusion of hospitalization payments in the social security program.

It's a Federal Problem

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minimum essential services, also has advantages and disadvantages. To the administrator, it has the advantage of monthly or other periodic payments to a few thousand hospitals rather than millions of checks to individuals; there is the disadvantage of having to work out contracts or agreements for the payment of fair reimbursements to the hospitals.

To the public, a service benefit has the advantage of guaranteeing essential hospital care to the patient according to his needs; but if it guarantees only minimum essential services, the patient would still have to pay out-of-pocket the additional costs that his hospitalization may have incurred.

To the hospital, the service benefit has the advantage that the institution is guaranteed a fair reimbursement for services furnished to insured persons, but the hospital, or a group of hospitals, would have to enter into an agreement with the insurance system as to the rate of reimbursement and would still have to collect from the patient whatever additional sums were owing for services not included in the insurance benefit.

Plans Might Be Combined

There is the possibility of combining some features of the cash and the service benefit. For example, even though the insurance benefit is a minimal cash amount per day of hospitalization and is owing to the insured patient, it might be assigned by the individual patient to the hospital. Such an arrangement would have some of the advantages and disadvantages of each type of benefit.

A two day conference of Social Security Board staff with the joint committee of the three national hospital associations and the special committee appointed by the board of trustees of the American Hospital Association was highly productive. There was a consensus that the specifications and the administrative operation of the system should make clear that the worker, rather than the hospital, is the beneficiary, but that the hospital should be assured receipt of payment through automatic assignment by the beneficiary of his benefit amount to the hospital in which the care is received.

It was also the opinion of the conferees that the per diem payments furnished as insurance benefit should be not a nationally fixed minimal cash amount but amounts reasonably related to the actual cost of providing basic services in the hospital in which the beneficiary receives care. Furthermore, such payments should in no case fall below a fixed national minimum or exceed a fixed national maximum.

Service Benefits Preferred

Although there are advantages and disadvantages from the administrative point of view, it is clear that a service benefit of this pattern is preferable, combining economy with maximum protection and security to the insured population. *If it appears clearly that these specifications are preferred by the hospitals, the Social Security Board has indicated that it would support such specifications in any recommendations it would make to Congress.*

The discussions have indicated that benefit payments to hospitals might be at rates that fall between $3 and $6 per diem for acute cases, the rate for a particular hospital or for the hospitals of an area depending upon the cost of furnishing service. The maximum might go to $7 if hospital costs continue to increase. The conferences have emphasized the importance of using a comparatively simple method of determining hospital costs in arriving at fair rates of reimbursement.

The simplified procedure recently proposed by the U. S. Children's Bureau for hospital services under the crippled children and the maternal and child health programs has been cited as an illustration of a desirable method for determining hospital costs.

The objective is to insure the patient against hospital costs for as long as he needs hospitalization. However, all who have considered this matter recognize the importance of proceeding rather cautiously at the outset and not promising more than the finances of the insurance system will surely afford. It has, therefore, been the general opinion that a social insurance system should start with a limited duration of benefit. It is expected that a system financed with 1 per cent of earnings could guarantee at least twenty-one or thirty days of hospitalization benefit, with extension of the benefit period up to sixty or ninety days after operating experience has shown that the finances of the insurance system permit.

The per diem rate of payment to hospitals for a minimum service benefit would have many advantages if it is comparatively high and uniform for the first twenty-one or thirty days, but it might then be at a lower per diem rate for hospitalization beyond twenty-one or thirty days and up to the maximum duration for which benefits may be paid.

If the rates of payment to various hospitals for the first twenty-one or thirty days are within a range of from $3 to $6 (possibly $7) per day, they might be within a lower range for days after the thirtieth, the actual rate to a hospital (or group of hospitals) depending on the estimated cost of furnishing minimum essential services.

It has been assumed that the social insurance system would not undertake to cover hospitalization for tuberculosis or for mental and nervous diseases after the diagnosis has been made.

Chronic Sick Need Care, Too

Provision might be made for the care of other classes of the chronic sick for limited but substantial periods of care in less expensive institutions suitable for such cases. Preliminary explorations suggest that payments might be in the range of from $1.50 to $3 per diem for the entire period during which chronic patients are in such special institutions, up to the limit of the maximum duration of benefit.

It has been an accepted premise that all qualified hospitals, whether voluntary, proprietary or governmental, should have the right to participate in the program. The standards for qualification should be fixed as high as practicable, taking full account and advantage of the good work that has been done and is being done in this field by the hospital, medical, surgical and other professional associations. An advisory

council, with adequate professional representation, should occupy a strong position in the social insurance system with respect to the establishment of standards and the stimulation of continuing improvements.

In attaining a coverage of approximately 11,000,000 persons, the Blue Cross plans have a great accomplishment to their credit. They have pioneered and they have demonstrated how much can be done, and how well, through voluntary insurance. The public, too, has learned that the cost of hospitalization is a readily insurable risk and that the primary interests of the public and of the hospital are the same. The whole nation has a right to expect the widest and most useful application of successful voluntary experience.

It is generally recognized that the Blue Cross plans have demonstrated, on the one hand, the relative ease of insuring middle and upper income groups and, on the other hand, the great difficulties of insuring low income groups through voluntary and local methods. Generally, they have failed to insure those who need insurance most, particularly those who are in the lower income groups and cannot, unaided, afford to pay the cost of insuring against their own hospitalization risks.

National System Can Protect All

The Blue Cross plans have demonstrated that a system capable of insuring most of the 135,000,000 people of the country is needed and is desirable. This is precisely what a national social insurance system can readily do and should do.

The relations that might obtain between the national social insurance system and the nonprofit group hospitalization plans are being considered. Although there have been preliminary explorations of this subject, much further work remains to be done. This subject deserves the careful attention of both the hospitals and the plan executives and trustees.

In the light of all insurance experience, voluntary and compulsory, social insurance against the costs of hospital care is both desirable and practical. By building upon the foundations of our present national social insurance system, the collection of contributions to cover the cost of hospitalization payments could be readily arranged without additional administrative machinery or cost. The system could cover a large proportion of the population of the country and thereby assure it ready access to needed hospital care.

It could pay benefits that would give at least a minimum and basic protection to the people. It could assure fair and reasonable reimbursements to the hospitals for the costs incurred in furnishing insurance services, thereby giving to the hospitals an assurance of financial resources so that no qualified hospital need be concerned from year to year as to the source of its basic income. It could still leave to each hospital its individuality and its administrative freedom to plan and conduct its own operations in its own way. It could give hospitals new and greater opportunities to perform their functions as community institutions.

Both voluntary and compulsory insurance systems have demonstrated beyond question that a social insurance system can enter into a financial partnership with the hospitals without getting into an administrative partnership. Social insurance aims to provide funds to assure needed health services; it does not seek the task of administering service institutions. Financial without administrative partnership is, in a sense, a watchword in the studies to design a sound American system of insurance against the costs of hospital care.

It Must Be Voluntary

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pulsory hospital insurance program, the argument for proceeding with such a plan at the present time is not convincing. Hospitals are overwhelmingly opposed to the establishment of a compulsory system now as was demonstrated by two recent surveys and in the official action of the house of delegates of the American Hospital Association in October 1942. Congress has indicated by its mood on other changes in the social security program that it is unreceptive at the present time. More than 8,000,000 citizens who ought to be participating in this decision are now in miliary service.

A large number of physicians are also in military service and can't make their positions known. Such an undertaking, because it relies upon active participation of hospitals, physicians and the public, must have full popular support to be successful. In addition to these considerations, it must be remembered that the administrative complexities of a compulsory hospital insurance plan make those of old age and unemployment insurance simple by comparison.

The frequent need for hospital care of those insured, the differences in the facilities available, the differences in the characteristics of medical practice by areas and the difficulties of control will require much more consideration than is suggested by the mere addition of an amount to be deducted from the pay rolls. Disregarding administrative difficulties as matters to be worked out later, would compulsory hospital insurance at this time create any new values? Will this proposal increase the number of beds available?

The effort of the Social Security Board during the last year and a half to obtain the advice of hospital administrators on the discussion of "cash reimbursement" to the insured *versus* "service contracts" paying hospitals direct is praiseworthy. It is also good selling technic to assume that the sale is made and to limit the choice to these two alternatives, but it does not solve any of the problems and begs the question whether such a program is a pressing need of our country at the present time.

National Income Fluctuates

The estimate of $600,000,000 yield from a 1 per cent pay roll tax is based upon the expected national income for 1943. However, there is no certainty, in view of the changes in the national income from year to year, that this figure will remain constant.

A hospital is something like a household in its ability to meet needs. It requires cooperation from the community of which it is a part

just as every member of the family is expected to help when it faces extraordinary demands. Adjustment for additional guests, even unexpected guests, can be made through the cooperation of everyone in the family.

Both the capacity of nongovernmental hospitals and the number of days provided to patients increased regularly during the recent period of lower national income. Blue Cross played an important part in making this possible. Thus, for instance, in 1933, 4661 nongovernmental hospitals provided care to 4,882,444 patients and though the number of nongovernmental hospitals decreased by 1942 to 4421, the number of beds increased and the number of patients served during 1942 also increased to 8,535,935. A regular pattern of growth by years in number of patients served may be observed from 1933 to 1942. This, of course, represented a greater effort on the part of local communities than provision for an "extra guest" suggests.

A more imaginative approach than simply stretching facilities and personnel was necessary and was made. But it is precisely this extra effort reflected in greater support from Blue Cross plans, local taxes, community chests and other voluntary efforts that has kept the total cost of hospital care at a realistic level.

Which Gives Better Care?

Everyone will agree that security from the fear of hospital bills is desirable and that people ought to be able to obtain hospital care as a right, not as a charity. While everyone may agree that hospital care ought to be made a matter of right, it cannot be so readily agreed that an over-all governmental compulsory hospital insurance plan will provide more hospital care or give people more for their money. Federal assistance is needed badly in certain backward areas of our country and to meet the needs of certain economic groups, but even here a pump priming job will be more effective and less costly in the long run.

In spite of the newer economics, it cannot be assumed that the black despair of periods of economic distress will not again have to be faced. Prudence in management requires planning against recurrence of depression. The concurrent reduced income from the pay roll tax and the increase in the demand for hospital care will, at times of low national income, increase the necessity for local responsibility, which cannot be obtained from a federally appointed "advisory" group.

In addition, the conclusion is inescapable that if a compulsory hospital insurance plan is adopted efficient public management will compel the federal government to own the hospitals and hire the personnel. The administrative controls necessary in a federal enterprise involving the entire population make this fundamental.

Let the Public Have the Facts

If events march to this result, should the fact not be plainly stated so that the American people may determine whether they desire such a system of medical care? One cannot take hold of a single strand in the provision of medical and hospital care on a federal government basis unless he is prepared to take hold of the entire rope. There is no stopping once, as Doctor Falk has indicated, 90,000,000 people are involved.

If compulsory health insurance is desired by American people, the ultimate cost of such insurance, the benefits people might derive in addition to what they get now, the probable long-time effect on the quality of medical service ought to receive sufficient emphasis so that fair judgment can be rendered.

Should the American public pay out more money and establish another large federal machine without assurance that citizens will get any more than they now receive? American health standards except for certain depressed areas are high in comparison with the rest of the world even where compulsory health insurance is in effect. Must every local problem be attacked nationally on exactly the same basis everywhere without regard to the realities?

If the principles adopted by the house of delegates of the American Hospital Association in October 1942 were enacted into law, the really pressing problems, such as (1) payment for the hospital care of the aged poor; (2) the lack of hospital facilities in certain rural areas and war centers, and (3) the inability of marginal income groups to pay their hospital bills, would become federal responsibilities under grants to states. This would not require greater annual contribution from federal taxes than from $75,000,000 to $100,000,000. Moreover, such annual contributions would not be continuously needed.

The development of local Blue Cross plans on a nation-wide basis, because they heighten the self-reliant character of local communities, will bring many new benefits to hospitals and communities, which will be reflected in better service and ultimate savings.

Social Security Board officials have greatly aided the development of Blue Cross plans. Their advice and encouragement have been acknowledged in many ways. Their attitude, however, has always suggested that any voluntary approach was by its nature only necessary ground breaking before the establishment of a governmental plan. While this position has a place in our thinking because it relates our work to the history of health insurance in other countries, it should be remembered that much of American life is without historic precedent. Indeed, as has often been pointed out by government officials, to the rest of the world this is America's strength.

Federal Encouragement Needed

If Blue Cross and voluntary hospitals working together were given the full and active encouragement by the federal government, such as is given to the Red Cross, a coordinated system of plans under voluntary sponsorship and local control would advance and strengthen all of the gains made in medicine and in hospital administration. The savings to the government, the stimulation this would provide local effort far outweigh benefits that might be derived from a compulsory plan.

Hospitals and citizens must determine the way. The hospitals of America have already spoken by adopting a program of action. It remains for the people of this country to be told effectively why hospitals have chosen the voluntary way so that an informed citizenry may make its desires felt. The argument on compulsory hospital insurance is not a minor bout leading up to the main event. It is the main event and the first bell has been sounded.

Botkin Hospital, Moscow Fights in the FRONT LINE

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THE American kept referring to "all-out" effort. The Russian was perplexed by the unfamiliar expression. "Total war," explained the American.

"Oh," said the Russian, with a nod of sudden comprehension, "you mean 'all for the front.'"

Every Russian knows that phrase. "All for the front!" is inscribed on thousands of banners that one sees everywhere in Russia. The words are to be met on almost every page of the Russian newspapers. They are a national slogan.

"All for the front" is the recurrent line on the posters in the reception room of the Botkin Hospital, Moscow. The same phrase is lettered on the bunting in the conference room. It is repeated frequently at staff meetings. It means what it says: the Botkin Hospital, Moscow's largest, today is entirely converted to war work.

The hospital was established in 1911. Its three departments in that period, therapeutic, surgical and infectious diseases, counted a total of only 340 beds. During the World War of 1914-18, this number was increased to 540, at the expense of extreme crowding. It was not until 1924 (when the Japanese, last of the 14 foreign armies of intervention, left Soviet soil) that the Russians were able to embark on the reconstruction of cities and hospitals. Once started, however, the growth and improvement were rapid.

At the outbreak of the German invasion in 1941, the hospital had 62 buildings, 2500 beds, a staff of more than 2000 and grounds covering 55 acres on October Field, near the city limits on the highway leading north out of Moscow.

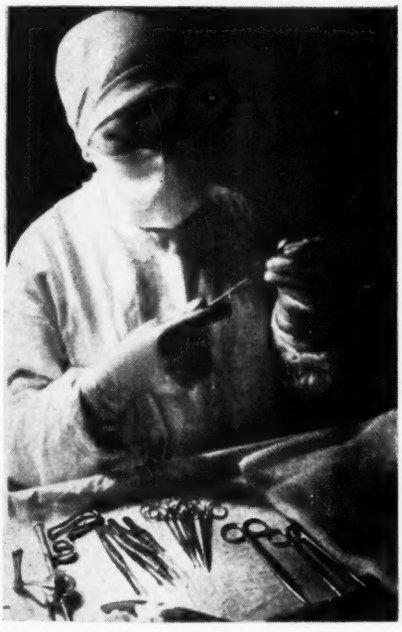
The Soviet government had named the hospital after Dr. Sergei Petrovich Botkin (1832-89), one of the founders of Russian clinical medicine. Under the many leaders of Russian medicine, more than 2000 doctors annually took refresher courses at the Botkin Hospital until the war caused this postgraduate study to be moved eastward to centers far from the fronts.

Like all Russian medical institutions, the Botkin Hospital was prepared, long before the German attack, to shift to a war footing if it became necessary. Air raid precaution units were formed and air raid drills were common. Most of the medical personnel had assignments in the Red Army Medical Corps reserve. Long before the Russians entered the war, women comprised well over half the entire hospital staff, including physicians and surgeons (51 per cent of Russia's M.D.s are women), and the proportion of women on the staff was steadily increased.

Shortly before the Nazi invasion, a blood bank was started, with a daily average of 400 volunteer "depositors." Each donor signed a personal note of encouragement to the soldier who would receive the blood transfusion. Individual notes with each blood donation are possible because the Russians use whole blood more often than plasma.

On June 22, 1941, when news of the German invasion reached the hospital by radio, Chief Physician Boris A. Shimeilovich, director of the hospital for the last twelve years, called a meeting of all the staff to discuss the hospital's war job. Plans for reorganization of staff and wards were approved and placed in immediate operation, and the staff voted to petition the Moscow soviet for classification as a military hospital, with corresponding functions. The petition was promptly granted.

The first weeks of the war were busy ones. Many civilian patients were moved to other institutions and other cities to make room for wounded Red Army men. The menace of air raids brought new problems. Emergency light and power installations were rechecked and enlarged. Windows were taped, sand-



Left: American surgical instruments are inspected on arrival in Moscow. Right: Nurse prepares to sterilize forceps received from America. Radiophotos, Russian War Relief.

bags were piled high around walls, A.R.P. units took over, evacuation drills were held and underground operating rooms and shelters were put in order.

Luckily, it was graduation time for the medical schools, and the country could call on 10,000 new graduates for medical personnel, more than half of them women.

The need for nurses was less acute, since Red Cross classes had trained 100,000 nurses' aides in the year prior to the invasion. Nevertheless, there were many jobs filled by men subject to the draft and this problem caused grave concern to Director Shimeilovich until the trade union of medical workers called upon all men of draft age to find and train women to replace them in their jobs. Each man in this category was asked to seek out a housewife or other jobless woman. Often, they chose their own wives, sisters or sweethearts.

In the first month of the war the comparatively few remaining young male workers still in mufti (most of them on the service staff) were each accompanied by a woman studying his job. The percentage of women employes rose to almost 90, and the percentage of women surgeons and physicians (many of them in army uniform) to more than 60.

The preparations for air raids proved effective. Hardly a month after the start of the German attack, Nazi planes bombed Moscow. Indignantly, officials of the hospital point out that the buildings were plainly marked with the international symbol of the red cross and that the site of the hospital must have been known to German aviators; it is marked on all maps of the city and German fliers of the Berlin-Moscow route had passed over the hospital hundreds of times before the invasion.

German bombs, however, take little account of Russian indignation, and the demolition bombs rained down that night in a steady shower of destruction. When the raid was over, the new children's wing was a mass of rubble. More than 100 children had to be moved to block five. Nevertheless, the A.R.P. unit and the staff, working until dawn to move the children, were proud: not a single patient had been lost.

The next night the bombing was resumed. Smoking mounds of debris were all that remained of block five. But the hospital has not yet lost a patient in the frequent raids. Staff members claim that it is not wanton *Schrecklichkeit* that motivates the repeated bombing of the plainly marked hospital. A wounded soldier, hit in his hospital bed, is out of action for good; a wounded soldier, left in the hospital, can rise to fight again, and the Russian doctors point out that 70 per cent of the wounded are restored to army duty.

In the autumn of 1941, when German troops were barely 60 miles from the Russian capital, the Botkin institution served as a front-line hospital. The wounded were brought in by ambulance direct from the firing line. Surgeons operated in rooms whose walls shook with the roar of shells and bombs, any many a building showed ragged, gaping holes where window panes had been.

Today the window panes have been replaced, the rubble has been removed, the firing has receded and the crash of shells is no longer heard, but the Botkin Hospital is still fighting a difficult battle against war-time conditions. Its 2500 beds are almost all occupied by wounded soldiers, with a sprinkling of guerrillas and Moscow air raid casualties. Each day hospital trains draw up at a siding alongside the hospital grounds, bringing a new contingent of war wounded. At the near-by airport, airplane ambulances land with a steady trickle of wounded soldiers and guerrillas. Army casualties are near the 6,000,000 mark, and air raids bring their toll of civilian wounded.

Beset as they are by problems of inadequate personnel, equipment, food and supplies, officials of the hospital nevertheless are undismayed. Part of the reason for their assurance is the fact that medical institutions are granted top place, along with the army, in priorities on whatever is available. That applies to food, heat, electric power and all the multitudes of things vital to the functioning of a hospital. Moscow homes may have gone without coal all winter, but the hospitals had the necessary fuel. In private homes and apartments electricity was rationed—one hour of a 75 watt bulb per evening for the average family, but the hospital had uninterrupted current.

The lot of the individual staff member was not so simple. Women of the hospital staff were among the

80,000 Muscovites who went out into the forests on their free days to chop timber so that their homes might have at least this meager fuel. The wood was carried by truck to fuel dumps in the city, but they had to haul it home themselves, on sleds, from the fuel dumps where they obtained their rations of wood. Daily working hours ranged from ten to twelve, and on occasion physicians and surgeons, as well as nurses, worked sleeplessly for several days on end. In leisure hours many of the staff worked on victory gardens.

Nevertheless, the strong breed of optimism must have been inspired in good part by the hearty support of the people of Moscow. The roster of hospital volunteers includes thousands of women, children and elderly men who devote spare time to helping the hospital staff. Trade unions and individual factory staffs have "adopted" units of the hospital, providing volunteer aides, auxiliary funds for entertainment of the patients and workers for a victory garden to add to the hospital menu. Theaters send troupes to this and other military hospitals to entertain in the wards.

A New York *Times* correspondent visited the hospital in 1942 and cabled to his paper: "A new wing of the hospital, which I visited, is probably more up to date than the majority of Russian war hospitals, although Russia has more modern hospitals and sanatoriums than any other country, even after allowing for the size of the Soviet Union. There certainly are hospitals in Russia where it is not possible, as here, to provide every patient with radio head phones and where there are more than five patients in a ward. . . . There was a 21-year-old Kazakh bomber pilot, who was reading Gorki's 'Mother'; a battalion commissar from the Caucasus, a hearty-looking extrovert; a Ukrainian born in Siberia and wounded at Medyn; a young Russian tank soldier who had suffered a broken leg at Volokolamsk, and a Latvian sniper who had fought at Narofominsk.

"'Do you want to go back to the army?' was the question I put to each of these men. It is a tribute either to the Red Army enthusiasm or to discipline that each man replied the same way, with a slow smile and the word 'konechno,'—'certainly.'"

The *Times* correspondent reported the arrival of American medical supplies and surgical instruments and stated that the supplies most needed were sulfa drugs, Peruvian balsam, American vaseline, tannin, bismuth and bandage material. Russian War Relief has been shipping these and other supplies from the United States, and the Russian War Relief nationalities division has undertaken the specific task of raising funds for supplies destined for the Botkin Hospital.

The importance of this project to the Botkin Hospital is inestimable. If the power supply is undependable, there are emergency installations. If fuel supplies give out, volunteers can turn lumberjack. If personnel is inadequate, housewives and other women can provide reserves. But if medical supplies are not available, there is little that can be done.

The vast number of casualties has proved a severe drain on the limited medical supplies with which Russia entered the war. Cables of thanks received by Russian War Relief are ample evidence of the deep gratitude with which the Russians have accepted American aid.

Opposite page: Many of Botkin Hospital's patients arrive from the front by plane. Ordinary passenger planes and outmoded training planes have been rebuilt as air ambulances, with specially designed enclosed stretchers attached to wings and fuselage. Right: Some wounded soldiers relax in a wing of the hospital, below which lies one of the victory gardens on the hospital's 55 acres of land. Radiophotos, Russian War Relief.

Seven Steps Toward

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SHORTLY after I began my career as a hospital administrator a member of the board stopped by the office and inquired if everything was going according to plan.

"It's going according to plan all right," I replied, "but I'm not so sure as to whose plan." The board member thought my reply was witty; I thought it truthful. I suspect that everyone in authority has on occasion felt the same way. Fortunately, on most occasions we have succeeded in repairing the break in the lines of authority, and operations have moved along according to plan. But why did the break in authority occur?

In the article, "So You Think You Have Authority," which appeared last month, I pointed out the manner by which authority is developed through orders and offered the conclusion that no wise executive issues orders unless he knows that compliance is possible and reasonable. The order, though, is only the directive impulse and, important as the correct impulse is, if we are to have control we must provide paths through which the impulse can function easily and directly.

Keep the Paths Open

These paths are the lines of authority. To maintain authority it is necessary to maintain the lines of authority. The orders and assignments by which coordinative action is possible must proceed down the path of authority in proper fashion, and it is the prime responsibility of the hospital administrator to maintain that path.

Most breakdowns in authority can be traced to abuses of the lines of authority. When personnel efficiency within a department falls off it must result from cause, for always cause must precede effect. What are the causes that effect the deterioration of authority? Perhaps the question can be best answered by an analysis of what not to do. Below are listed seven rules for the maintenance of authority by observing the lines of authority.

1. The lines of authority must be definitely known to every employe. It is clear that if the paths of control are vague there will be confusion. If the maid on second floor is assigned one duty by the housekeeper and another by the nursing supervisor she is forced to hold one of the orders in contempt. Conversely, when the maid runs into difficulties with her work much time can be saved if she has a definite knowledge as to whom to carry her problem for solution.

Several means have been developed to aid in making clear the scope of authority and responsibility of each member of the organization. The usual means is the organization chart by which each position is shown in relation to the other positions. A more elaborate means is the organization, or employes', manual. The least that should be done is to give every employe a thorough introduction to the exact source of control to which he must respond.

Much conflict among supervisors can be spared if they, too, have a clear understanding as to the limits of their jurisdiction. Interdepartmental conflict is least known in those hospitals where the supervisors are given an exact picture of the scope of their position and are made to understand that there is no possibility of usurping more.

2. The lines of authority must not be short circuited. There is no principle of executive conduct better established than this. To ignore it is to destroy authority, discipline and morale. This rule applies most aptly to the relations between the board and the administrator. Many words cannot make plainer the reason for most ruptures between the governing body and its representative.

Astute business men have been guilty of violating this principle in their conduct as hospital trustees while observing it strictly in their plants. They do not seem to attach the same significance to going over the head of the superintendent of a hospital as they do to going over the head of the superintendent of a foundry.

The abuse of this rule is not confined to the boards of trustees. All too frequently it is a habit of the administrator. A poll of our department heads might startle us with the number of times we have been guilty of side-stepping delegated authority and engaging in what, in the true sense, is meddling.

Such action naturally has an effect on the whole working force, causing loss of respect for superiors. The employe cannot be expected to entertain any more respect for his superior than does the administrator who placed her there. The meddling executive who goes around, or the impatient executive who goes over the head of, his supervisors not only robs his supervisors of respect but destroys the organization by which his own worth is measured.

One Person Gives the Orders

3. Every member of the organization must have line responsibility to someone and that person must be the one who gives him his orders. This was partly borne out under the first two rules. It is used here in the positive sense, that is, not as a "don't" to avoid confusion but as a "must" to ensure discipline. Each employe must be made to recognize that he is subject to the authority of the supervisor within his department, and this includes the right to hire and fire him, at least as far as that department is concerned. The supervisor who is giving the command must be the same person who controls the tenure of employment; if not, one of the necessary influences that any department head must have over her subordinates will be lacking.

A side approach to the same thought is that only one person should have direct authority over an employe. Any other manner of organization produces dual subordination with consequent deterioration in efficiency and morale. It is standard knowledge that few men can serve two masters well. I suspect that more wisdom would be shown in saying that few masters are

Maintaining AUTHORITY

capable of sharing mastery over one worker well.

4. The lines of authority should be as short as possible. The more common phraseology used is "eliminate red tape." This whole problem lies in the proper delegation of authority. The administrator who demands that he interview every bus boy hired in the kitchen and reserves for himself the right to choose the colors used for painting the rooms in the students' home may have everything under control, but it's a good bet that he is controlling the little things while the big ones go unattended.

The odds are good, too, that few progressive suggestions move up the line to him from those below, for they have no opportunity to exercise initiative, to develop through experience in using authority. The main idea seems to be to receive instead of give and to the receiver there is little incentive to progressive thinking.

Decentralization Saves Time

The decentralization of authority facilitates the flow of information. It reserves to the administrator the broad duties and delegates down the line the authority to make decisions regarding specific situations. Such use of division of work obviates the necessity for passing ideas up and down the lines of command and eliminates the waste of time and effort incident to lack of authority.

5. Lines of authority must be coterminous with lines of responsibility. The preceding paragraph attempted to make the case for decentralized authority. But coexistent with that authority must be responsibility.

The maintenance of a balanced organization depends upon the existence throughout the hospital of a reciprocal relationship between responsibility and authority. An illustration of this may be found in the question of who shall have the authority to purchase drugs, the pharmacist or the purchasing agent? If the pharmacist is given the authority to do his own buying then he must be held accountable for adequate supply, for inventory of reasonable size, for good quality and for best price. With every right there must be a corresponding duty.

To my notion the main burden on the administrator in assigning responsibility is the provision of means of judging performance. Almost every person gives better performance if he knows that a measuring rod will be laid beside his work. Means of measurement are available by the use of standard costs, as in the laundry and kitchen. Other service departments can be fairly judged by existing means. All departments can be measured for cost against the budget. But the professional service from doctors and nurses cannot be judged by cost alone.

6. The lines of authority must be kept open at all times. This rule is more particularly applicable to hospitals than perhaps to any other type of organization. The hospital must operate twenty-four hours a day and its work is emergency in nature. Someone invested with authority must always be present for there is no halt in the work. This problem causes little concern if department heads schedule their personnel's hours correctly and have been wise in the choice and development of their assistants.

The matter of development of assistants is of primary concern. If the department head has reserved all authority and not allowed any discretion to the assistant then the assistant is not prepared to make the decision necessary to keeping the lines of authority functioning at all times.

If the Boston night club fire had occurred in your city would your assistant department heads on duty at that time have been able to handle the situation? Would they have been able to issue the orders necessary to coordinate the activities of their departments? That, I think, would be the supreme test of keeping the lines of authority open. The ultimate test is the continuity of efficient performance.

7. The lines of authority must at every point be completely supported; or, better stated, every challenge of authority must be met squarely and firmly. Disorganization is a gradual process and results from continued attack upon authority. The change is most often one of attitude more than overt action. Since the only purpose of authority is to achieve performance we measure the prevalence of authority by the degree of efficient performance obtaining. If competent orders are issued to competent employes then inefficiency can only be attributed to disregard, partial or complete, of orders.

Discipline Must Be Impartial

Disregard of orders is an attack upon authority and calls for prompt discipline. Nothing is to be gained by indecision or indifference. The employe expects fair and impartial discipline. His respect for the authority existing in the hospital will be not one bit greater than that of those enjoying that authority. His evaluation of that respect is based upon the reaction resulting from his disregard of it. It is a good rule that all disciplinary action be taken by the person to whom the employe has direct line responsibility, for he is the person whose authority is challenged.

Discipline must be uniformly firm, regardless of who has disregarded orders. Department heads must be held amenable for breach of orders to the same degree as the employes under them.

It should be an inflexible rule that every order issued in the hospital will be efficiently carried out or that it will be countermanded. Before an order is issued decision must first be made as to how it will be followed up. An order once issued must not be forgotten no matter how trivial it may be. The effort necessary to see that an order, standing or specific, is efficiently carried out may be excessive, but the effort will pay dividends by safeguarding the habit of full response which the employes must develop if authority is to be maintained.

RADIOLOGICAL SERVICE *Advanced by* DESIGN

IN DEVELOPING the plans for the new department of radiology of the Hospital of the University of Pennsylvania, the location and general arrangement of the x-ray film processing facilities were among the first factors considered.

It was recognized that the film processing suite should form the focal point of the diagnostic section of a department of radiology, inasmuch as all the x-ray films from the various radiographic rooms are delivered to it, and the finished roentgenograms are passed directly on from it to the filing room and thence to the film viewing rooms.

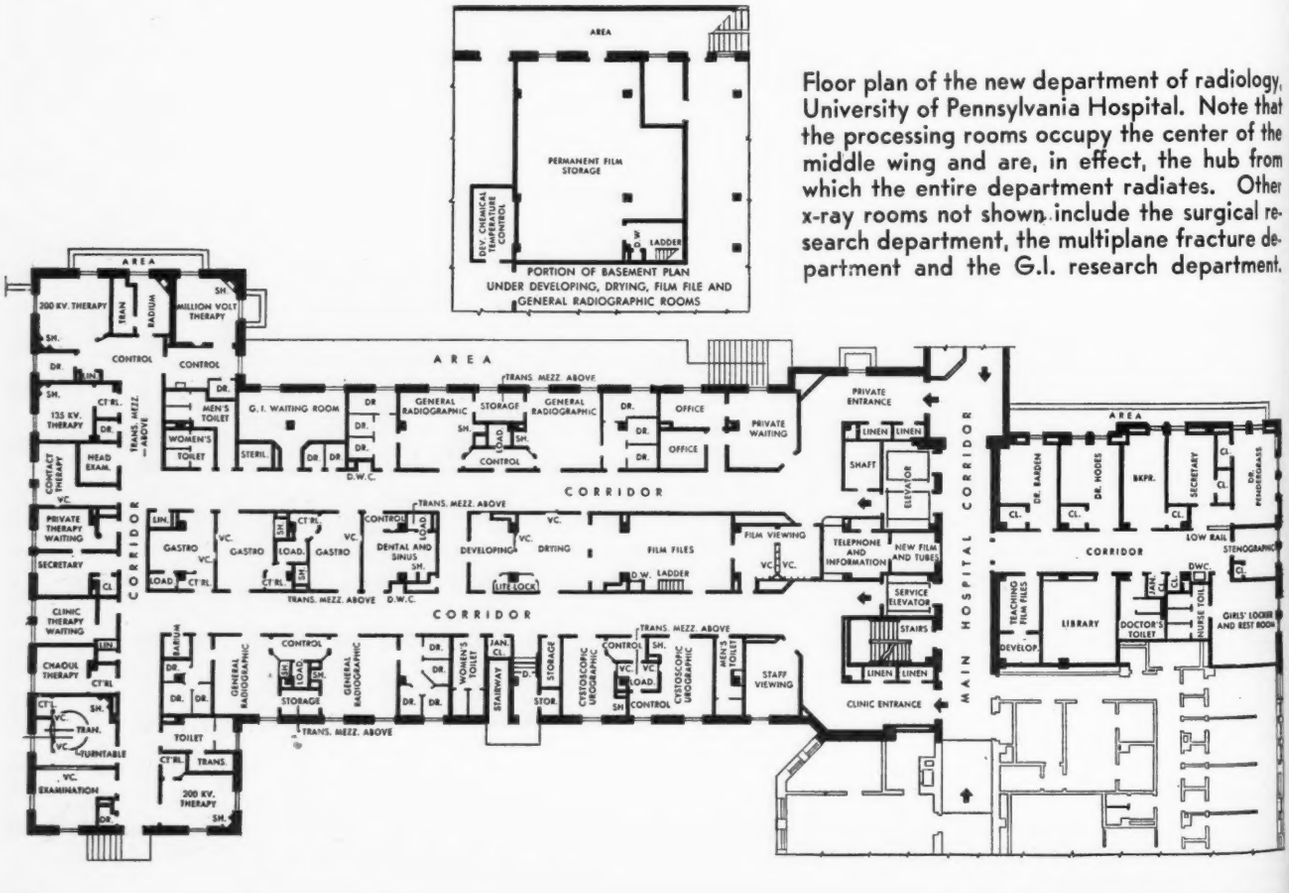
For maximum efficiency, the processing rooms had to be built to handle the greatest number of films per day that might be used with the x-ray department operating at full capacity. If this concept was followed there should be no danger of a bottleneck occurring in the developing room on a busy day. A study of the plan will show how this has been adapted to the needs of our radiologic clinic.

Throughout the department are six film loading rooms where exposed films are removed from the cassettes or exposure holders, identified by a photographic marker and placed in lightproof carrying cases. These carrying cases go into passboxes in the wall of the developing room.

No cassettes ever leave the radiographic rooms. This eliminates any possibility of moisture or solutions being splashed on the intensifying screens and puts the responsibility for the condition of a group of cassettes on the individual technician who is in charge of each radiographic room.

Within the developing room the exposed films are mounted on developing hangers, which are placed in stainless steel baskets accommodating eight hangers each. The loaded basket is handled as a unit through developer solution, turbulent rinse water, hypo solution, final rinse water and dryer cabinet. When the film is removed from the dryer it goes immediately into the filing envelope.

By this basket system of handling scratching of films is eliminated and time is saved because the unit handled is eight films instead of one.



Floor plan of the new department of radiology, University of Pennsylvania Hospital. Note that the processing rooms occupy the center of the middle wing and are, in effect, the hub from which the entire department radiates. Other x-ray rooms not shown include the surgical research department, the multiplane fracture department and the G.I. research department.

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Overhead cranes are used to facilitate handling of the basket full of films between tanks and into the dryer. The cranes are mounted on tracks in the ceiling parallel to the tanks and are counterbalanced so that they can be raised and lowered with slight effort.

One of the innovations of this processing suite is the fact that the films are transferred out of the darkroom into a room with full illumination as they go through the hypo tank. As much as possible of the work of handling the films is thereby done in ordinary light and films are available at the earliest possible moment for reading in emergency cases.

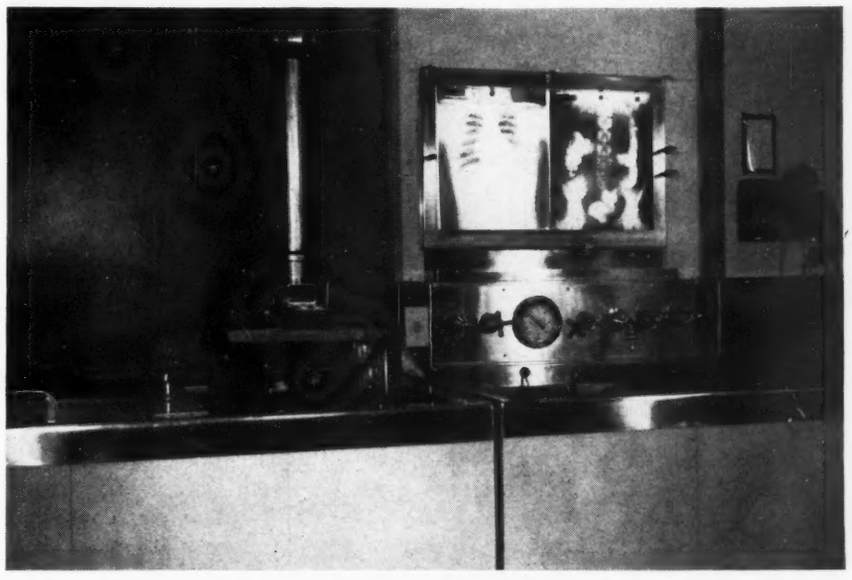
The darkroom and fixing (or light) room are connected by a short corridor that serves as a light-lock. The doors at each end are interlocked by electric solenoids, making it impossible to open both simultaneously.

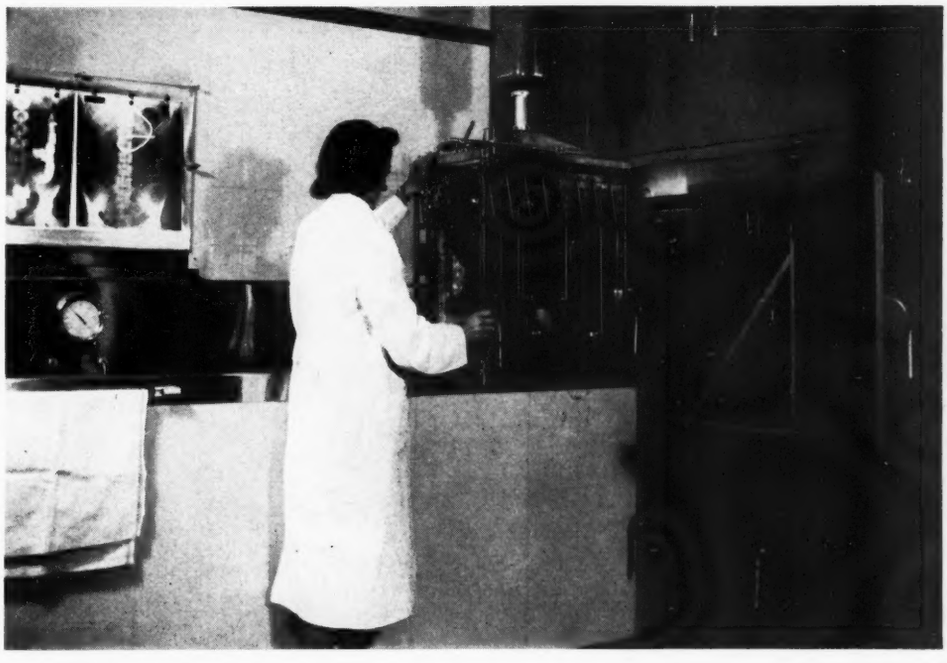
The space in the processing tanks is allotted as follows: two 30 gallon tanks for developing; two 60 gallon tanks for fixing, and a main wash tank holding 2 tons of water, approximately 485 gallons. Baskets are carried down the length of the main wash tank on a chain drive timed to 25 minutes. An auxiliary wash tank is provided for more rapid washing when films are to be read wet. All these tanks are made of stainless steel faced externally with green glass tile to match the green glass tile of the walls of the rooms.

Water for the temperature control baths and the wash tanks is supplied from units in the basement. These units supply up to 300 gallons of constant temperature (68° F.) water per hour, winter and summer even if there is as much as a 25° F. temperature differential in the city water supply.

The tanks are supplied by two separate streams of water as follows: One stream feeds the developer temperature control bath and is directed from there to the hypo temperature control bath and on to the auxiliary wash tank. The other source of water supplies the main wash tank and goes from there to the turbulent rinse bath, located between the developer and fixer tanks.

When one walks into this processing suite one of the most striking features is the apparent absence of plumbing, for not a pipe is in sight anywhere. The actual plumbing, although hidden, is necessarily quite





Above: The larger of the two rooms of the processing suite, which is illuminated by ordinary light at all times. The wall separates the darkroom from this light room. At the left are two 60 gallon fixing tanks which open in the darkroom as well. Right: In another corner of the light room a basket of films is being moved into position in front of one of the dryers.

Above: Before taking an x-ray film the technician measures the patient's chest to determine the necessary exposure time. This is part of the new equipment located in the radiology department of the new Crothers Dulles unit of the hospital.

Below: Physician at the control of the biplane fluoroscope, which is used to locate an object that a patient has accidentally swallowed. This apparatus was developed by Dr. W. Edward Chamberlain while working at Temple University in Philadelphia.

complicated with valves to control rate of water flow, separate plumbing to the pump for the turbulent rinse tank and plumbing from the overflow standpipes to precoolers in the refrigerating units. In addition, there are facilities in the basement for mixing solutions and pumping them up into the solution tanks above.

The dryers are specially constructed and occupy the wall between the processing suite and file room. Each dryer compartment accommodates one basket of films, which is removed into the filing room when the films are dry. As the dryers are at present constructed, this darkroom unit has an eight hour capacity of approximately 750 14 by 17 inch films. If the need arises the dryer capacity can be increased or the drying time shortened.

After the baskets and developing hangers have been emptied, a dumbwaiter carries them up to a return tunnel near the ceiling, which also serves as a storage space. Below the darkroom end of this return tunnel there is always an empty basket standing on the counter ready to be loaded. When one is removed, the carriage travels to the ceiling and returns to the darkroom with the next empty basket.

Many ingenious little devices make the processing work easier and more efficient. The floor space in the darkroom has been purposely kept at a minimum to save time and steps. A 5 gallon replenisher developer bottle is arranged on a special carriage which is easily removed and replaced yet folds up into a cupboard in the wall when it is not in use. The illuminating boxes in the finishing room are placed above the wash tanks and exhibit racks for mounting the wet films that are to be read. The towel racks are of a nonbreakable plastic. The fixing bath, communicating as it does with both darkroom and light room, has safety devices connected to its sliding doors so that the doors at both ends cannot open simultaneously.

Since the new department was opened about a year ago the utility of the processing rooms both in design and performance has passed every test in actual practice. Along with the improvement in appearance, the new darkroom has greatly exceeded the efficiency of the older, standard processing room that had previously been employed.

The Lessons England Learned

help to fill the gaps in our understanding of air raid injuries

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THE publication of every experience in the reception and treatment of air raid casualties is of great importance. It is by the pooling and collection of all results, and even impressions, that many gaps in our knowledge will be filled. At a Royal Naval Medical Service hospital in England there has been a special opportunity for testing planned resuscitation and operative schemes.

It was found best to admit patients into resuscitation wards irrespective of their condition and then filter them through into the operating theaters or other wards. Patients who were obviously severely wounded were placed in beds on one side of the ward so that they could be examined first. When the first resuscitation ward was full, admission was diverted to the second.

Clothing Must Be Removed

The patients were placed between warmed blankets and the clothing was completely taken off in every case. It was found that delay in taking off clothing results in important injuries being missed, and the thick, often damp clothing cannot be penetrated adequately even by heat from shock cages.

To prevent overlap and confusion, only one examining team was utilized, and it moved round the ward methodically examining the cases in strict rotation. A list for operation was made at an early stage and this enabled the operating tables to be fed within an hour of receipt of the casualties. This operating list was, of course, subject to frequent revision, but unless it was begun early it was inevitable that it would prove difficult to deal with patients in the "safe period."

We were impressed with the necessity for examining the whole body from top to toe and it was astonishing how small but serious wounds could otherwise be missed. The best and simplest method of recording injuries was under anatomical regional headings, such as head, arms, chest, abdomen, legs and spine.

The average degree of shock encountered in air raid casualties far exceeded that seen in the casualties of civil life. The nature of the injuries and the state of the blood pressure were the best signs of its gravity. Early rapid resuscitative measures were strongly advisable. Severe shock had to be tackled wholeheartedly. Besides heat, elevation of the foot of the bed on 18 inch blocks and intravenous therapy with blood, plasma or reconstituted serum in large doses were necessary. A cannula was always inserted into a vein in cases requiring intensive antishock treatment over a long period.

Seriously shocked cases must be given plasma in quantity and given it quickly. It should be possible to run in 2 pints of plasma in twenty minutes and further quantities up to 6 pints at slower rates as the patient's condition improves. The blood pressure is usually the best guide to the success or failure of plasma or blood transfusions.

Systolic Pressure Tells Story

If the systolic pressure does not rise with 3 pints given quickly it is unlikely that the patient will recover. Patients have been seen with systolic pressures below 50 mm. Hg. and have improved at the rate of 10 mm. Hg. for each pint of plasma or blood given. It is useful to maintain a sphygmomanometer cuff on the patient's arm throughout treatment and easy to train the ward staff to take the systolic pressure accurately.

In certain cases admitted early after injury the blood pressure was either maintained or raised for a variable period. In such cases the type and degree of injury led one to suspect that a fall was imminent and this could be prevented if plasma was given to compensate for the fall in circulating blood volume. Oxygen therapy with the B.L.B. mask was frequently used and with obvious immediate improvement in color, pulse and depth of respirations. If the patient did not tolerate the mask it usually meant that he did not require oxygen. Many patients asked for it to be reapplied if it was removed. Instruction in the use of the mask had been part of the regular training of the ward staff.

Proper Splinting Helpful

Among other adjuncts to the treatment of wound shock are the intelligent temporary splinting of fractures, especially those of the femur; the utilization of early skeletal traction under local anesthesia in the ward, and the local blocking of injured limbs with 1 per cent procaine.

Resuscitation measures are only temporary in their effect in most of these cases. When operation is delayed a patient may reach a peak of improvement and then relapse despite all further resuscitative measures. Patients must, if possible, be operated on when on the up-grade. Approximately 70 per cent of the cases given intense preliminary resuscitation survived operation.

Reprinted from the Lancet **2**:26 (Dec. 27) 1941. A more detailed account of these casualties appeared in the Journal of the Royal Naval Medical Service for October 1941, p. 330.

CASES ANALYZED

	Total	*Died*
Head injuries	35	4
Chest injuries	3	2
Abdominal injuries	8	8
Compound fractures	22	5
Simple fractures	34	0
Bomb-splinter wounds of soft tissues	37	0
Laceration of soft tissues	7	0
Burns	8	0
Eye injuries	4	1
Minor injuries	71	0
Unclassified	16	4
Total	245	24

A consecutive series of 245 air raid casualties aged from 20 to 50 years, most of whom had previously been healthy, are analyzed in the accompanying table. Nearly all were admitted within one to three hours of the injuries, and all patients admitted alive into the reception wards are included. The death rates have been calculated up to a period of a week from the day of injury. The total fatality rate was 10 per cent.

Head Injuries.—These included scalp lacerations, concussion and closed or compound fractures of the skull. Altogether there were 35 cases (14 per cent of all cases), 9 being scalp injuries and 12 concussions. The fatality rate was 11 per cent. The diagnosis of these head injuries was simple in some cases but in many with other multiple severe injuries the degree of shock made it difficult to assess the cerebral lesion. Accurate neurological examination was often impossible in the early stages of examination.

It was made the rule to take every scalp laceration to the theater for thorough exploration and toilet of the wound. Most of the compound injuries of the skull were caused by falling debris, and it should be more widely realized that steel helmets are as useful indoors as out. There were eight cases of compound depressed fracture of the skull, and six were fit for operation, all of which recovered.

Abdominal Injuries—This series was extremely depressing. There were eight cases (3 per cent of the total), of which only four reached the operating table and all subsequently died; three of these had hopeless lacerations of the abdominal contents and died immediately or soon after abdominal closure. In one case, in which the liver had been injured by a bomb splinter, the patient died a few days after operation from a pneumonic infection and a small subhepatic bile-stained abscess.

Chest Injuries.—Of the three patients admitted with chest injuries, two were inoperable and died shortly after admission. Both these patients had multiple bomb-splinter penetrating wounds with other compound injuries. The one patient who was successfully operated on received a small bomb-splinter wound in his left lower chest and the fragment actually lodged in the right side of the chest. The only operative intervention was excision of the entry wound. He subsequently developed a hemothorax on the right side, which was treated by aspiration.

Compound Limb Injuries and Soft-Tissue Lacerations.—These 65 cases made up 26 per cent of the total. The value of the closed-plaster method was confirmed. Among its other advantages it enabled amputation cases and others to be transferred rapidly to base hospitals. This was found to be particularly important from the patients' point of view, for with the prospects of further nightly raids they were likely to be nervous or sleepless. The wounds were widely and thoroughly excised, sutures were avoided wherever possible and the wounds packed with vaseline gauze. By adopting the pattern technic for plastering the limbs much time was saved. A hip spica could be applied in eight minutes.

All cases were examined radiologically before operation; in this way the presence of metal fragments was confirmed and their type and localization noted, so that the scope of the operation required for excision of the track could be assessed. The small penetrating wounds of fascia with gross damage of underlying muscle were a real danger unless adequately treated. Complete plaster immobilization was as essential in soft-tissue limb injuries as in compound fractures.

Bomb-Splinter Wounds of Soft Tissues.—There were 37 cases (14 per cent of the total), 15 of them involving either the buttock or thigh. The high incidence of such wounds is presumably due to the prominence of the buttocks when people throw themselves down for protection. There were no deaths in the soft-tissue injuries, which included two cases of severe local gas gangrene infections; these recovered after wide local drainage, serum and early immobilization in closed plaster. There were an additional seven cases of lacerations caused by glass. It was found safe to employ primary suture for these inside of twelve hours.

Compound Fractures of Limbs.—Eight of the 22 cases required amputations. Two patients requiring upper-limb amputation recovered, but four out of the six patients whose lower limbs were amputated (two double amputations) died. Subsequent renal failure, with a probably associated cerebral lesion, was responsible for two of these deaths. Of the remaining 14 compound fractures, including four of the femur, all recovered except one patient with aortic incompetence who collapsed and died suddenly 24 hours after the injury.

Of special interest was a case of compound injury to the humerus in which an acute Volkmann's ischemic contracture, with all the typical signs, developed 12 hours later. The brachial artery was explored and found to be contracted to a diameter of 1/6 inch in its entire extent. Periarterial sympathectomy and excision of an arterial segment failed to relieve the arterial spasm. Both legs had to be amputated for crush injuries in this case and the patient collapsed and died shortly after the operation.

Simple Fractures.—These 34 cases (14 per cent of the total) illustrate the great importance of a specialized knowledge of the treatment of fractures in air raid cases. The upper and lower limbs receive an equal proportion of injuries. A patient with a dislocation of both hip joints and multiple pelvic fractures was admitted with severe shock (systolic blood pressure unrecordable) after a heavy mass of concrete had fallen on his sacral region while he was bending down. After resuscitation with 3 pints of plasma and early skeletal traction through the tibial crests, he recovered.

Burns.—With certain exceptions burns were treated successfully with tannic acid 5 per cent and silver nitrate 10 per cent. This produces a rapid coagulum, an important point when many cases have to be treated. Certain areas were never tanned. These included the eyelids, lips, genitalia, ears and fingers. Burns of the fingers were treated

on light plaster splints in the position of function with ambrine wax applied on strips of gauze. This method has given excellent healing and good functional results when the initial injury was not too severe. The bad results attributed to tanning methods are more likely due to the initial damage by the burn. The ambrine wax method is, however, much more comfortable and indeed has been applied to other areas.

Eye Injuries.—There were only 4 cases of eye injury and in two of these the damage resulted from metallic splinters, for which the affected eyes had to be removed. Multiple fine corneal foreign bodies and corneal abrasions accounted for the other two cases.

Minor and Unclassified Injuries.—There were 71 cases of minor injury (29 per cent of the total), most of them having minor lacerations, sprains or slight shock. Many required x-ray examination. In the unclassified list are included 16 patients (7 per cent of the total), several of whom had multiple injuries or had been buried for some time. There were two who developed all the signs of a crush-syndrome and lesion of the lower limb and recovered, and four cases of blast lung, two of which were diagnosed by x-ray. A stout bronchitic man, with no other lesion except a fractured radius, died after a hemoptysis which suggested a blast lesion. Included in this unclassified list are three patients with multiple bone injuries to the trunk who died shortly after admission.

There were two cases of spinal-canal injury. Both were explored and the missiles removed. One patient recovered fully but in the other there was damage to the cord with paraplegia.

Antitetanic serum was given as a routine in all wounds, including burns; no case of tetanus occurred. Patients with muscle damage were given 8000 units of antigas gangrene serum. No definite conclusions have been reached on the practical value of chemotherapy either generally or locally. During actual convalescence, after the study of a number of blood counts in a series of cases, it was found that fresh blood transfusion is of great value in the postoperative period.

The importance of close observation of urinary output and renal efficiency must be particularly stressed to the nursing staff, especially in amputation cases and crush injuries. Postmortem examinations whenever possible are desirable, but owing to administrative difficulties in obtaining the necessary permission much material is being lost.

Aides Speak for the Hospital

SISTER M. PATRICIA, O.S.B.

ST. MARY'S HOSPITAL, DULUTH, MINN.

TODAY, a visitor or patient going through the corridors of our hospitals sees not only the busy doctors, nurses, dietitians, librarians, and various technologists in their crisp white uniforms but volunteer workers garbed in an array of colors. These may be the Gray Ladies, the Girl Scouts, members of various organizations and last, but not least, the Red Cross nurses' aides.

These aides represent a well-organized group of trained workers who have more than accomplished the objectives set forth in the syllabus prepared by the Red Cross. Their willingness and spirit of sacrifice have assured us that they count nothing too much to give in the service of their country. This spirit has been a source of inspiration to the personnel and to the patients.

On the other hand, one might ask, "What do the aides think of the hospitals?" Do we hospital administrators have an opportunity to further our public relations program? With these thoughts in mind, a questionnaire was given to 40 Red Cross nurses' aides who had completed the course at St. Mary's Hospital, Duluth, Minn. The response was gratifying.

All graduates admitted that they enjoyed the course. One amplified her statement by saying: "I enjoyed every hour to the fullest extent. I don't know when I've enjoyed a course so much and benefited so greatly."

Asked what points about the hospital impressed them most favorably, the aides listed: orderliness, cooperation of the patients, efficiency of the medical staff and hospital personnel, elimination of unnecessary movements and the gracious reception given them by the hospital department heads. The hospital teamwork seemed to be a source of amazement. One marveled at the "speed with efficiency." Another was much impressed with the amount of equipment that is needed to care for the sick.

The following answers are typical of those given to the question: What personal satisfaction did you derive from your service? "The feeling of trying to do my bit for defense." "The grand feeling that you are doing a worth-while job and learning the correct method in case of emergency." "The deep satisfaction of feeling that I can in some small way serve both humanity and my country in this terrible war."

The aides are of the opinion that they have gained personal values, such as: "Valuable information to use in later life; training to care for my family in health and sickness." "The knowledge of being able to assist when needed in hospitals and in emergency and to be more understanding of the sick." "A deeper understanding of life." "A more acute sympathy and a greater ability to project it." "More confidence in hospitals."

That their experience more or less altered their previous conception of hospitals is shown by these statements. "The course has taken away all fears I had previously of hospitals." "Before my course I had no idea of how a hospital functioned. I now realize some of the problems, the great responsibility, the need of efficiency, economy and good management." "My ideas of hospitals remain about the same, except that I was a little surprised at how easily the nurses' aides were able to fit into the whole system."

There were other answers given, but those quoted are representative. I think you will agree that, in addition to the material help they give, the Red Cross nurses' aides are a means of establishing better public relations between the community at large and the hospital.

Honolulu Has a BLOOD BANK

WILLIAM D. MERRILL
C. W. DICKEY ASSOCIATES
ARCHITECTS, HONOLULU, T. H.

THE Honolulu blood plasma bank was opened to the public on July 16, 1942. Not a makeshift, this structure was planned and built for its purpose: the procuring and storage of blood and the processing, treatment and storage of plasma.

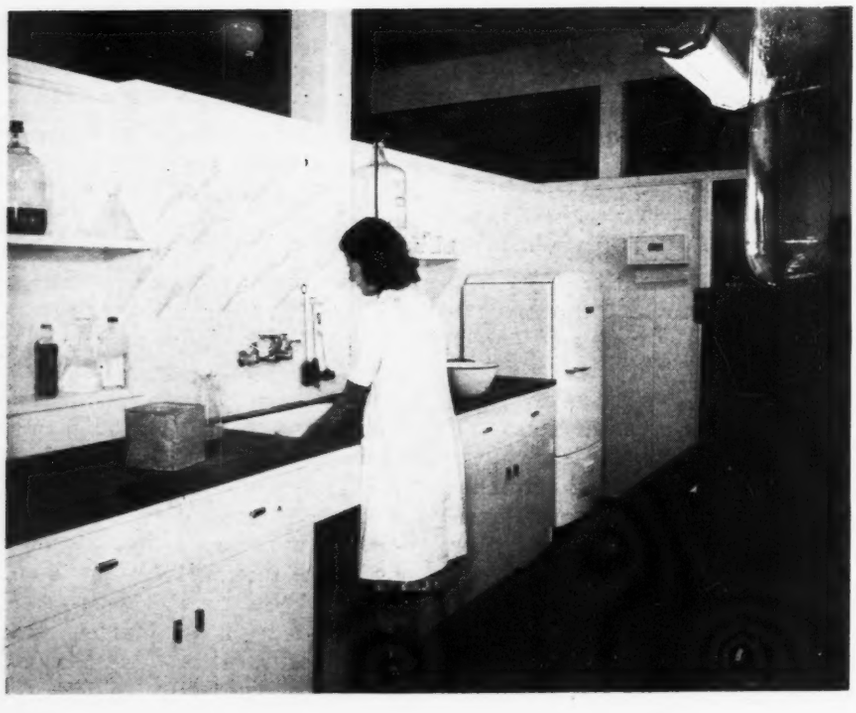
While the building is unique, the architects were furnished an ample fund of data that had been accumulated by Dr. F. J. Pinkerton, the director, and his staff. They had been functioning as a smooth and efficient team since the blitz on December 7, although severely handicapped by lack of proper facilities. Their early experience had been gained during the period from June to November, 1941, when the blood bank was started as a project of the public health committee of the Honolulu Chamber of Commerce.

These new quarters were built by the Territorial Office of Civilian Defense, under which the bank now operates, and are located on the grounds of the Queen's Hospital, Honolulu's medical center. Here the hospital facilities are available for emergency use and the plasma is readily available to the hospital staff.

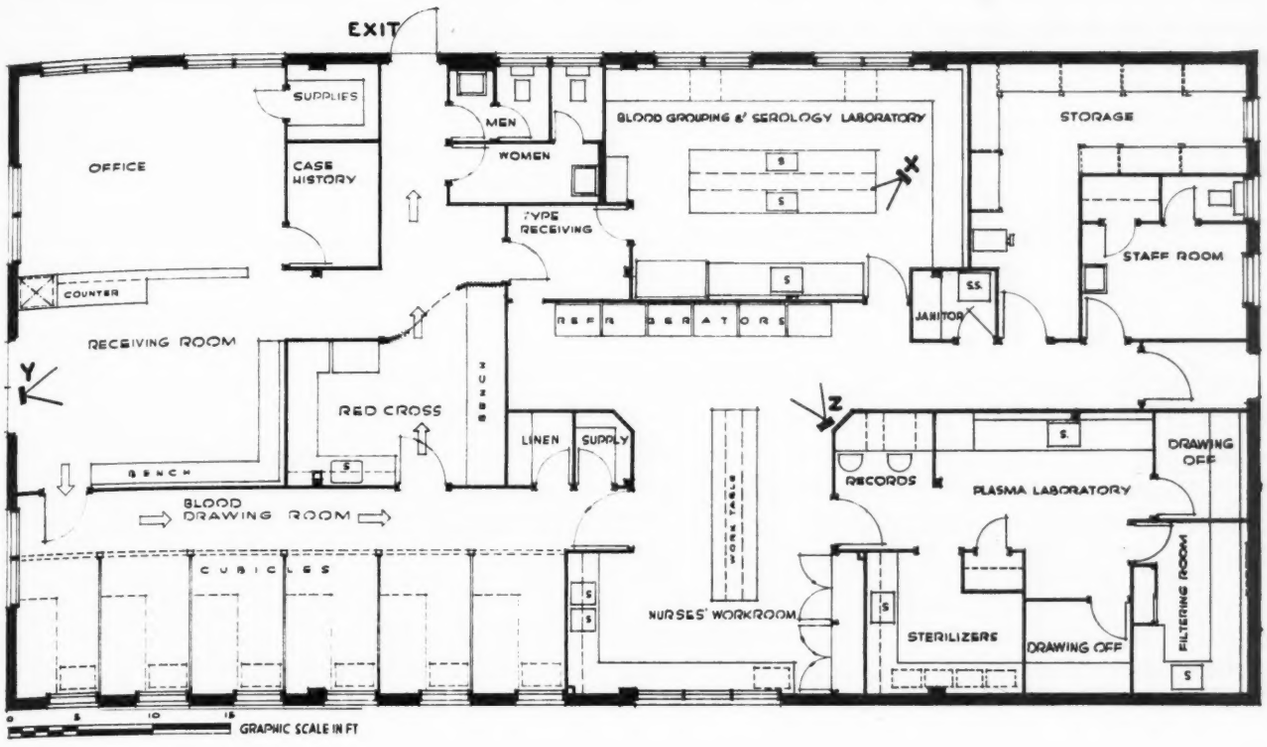
The building houses four distinct departments, each with its individual requirements. These are, first, the administrative offices with public rooms for donors; second, the blood drawing room and adjacent nurses' workroom; third, the laboratories, and, fourth, the American Red Cross motor and canteen services.

The individual enters a lobby of pleasant, homelike appearance and is registered at the desk, interviewed in a private booth for case and personal history, and sent to the laboratory for blood grouping and hemoglobin tests. If he is here for this purpose only, he may then leave the building.

If the person is to be a donor, he waits in the lobby for his turn in the blood drawing room. In this room are six compartments, separated only by curtains which may be withdrawn to provide for an increase of capacity in the event of another attack. From here the donor enters a secluded waiting room where he may rest and be served



Above: This is the pleasant, home-like lobby that the prospective blood donor enters either to be interviewed or, if that has already been done and he has been accepted as a donor, to wait his turn to go to the blood drawing room. Left: The serology laboratory. Before a donor is accepted he is sent to the laboratories for blood group and hemoglobin tests.

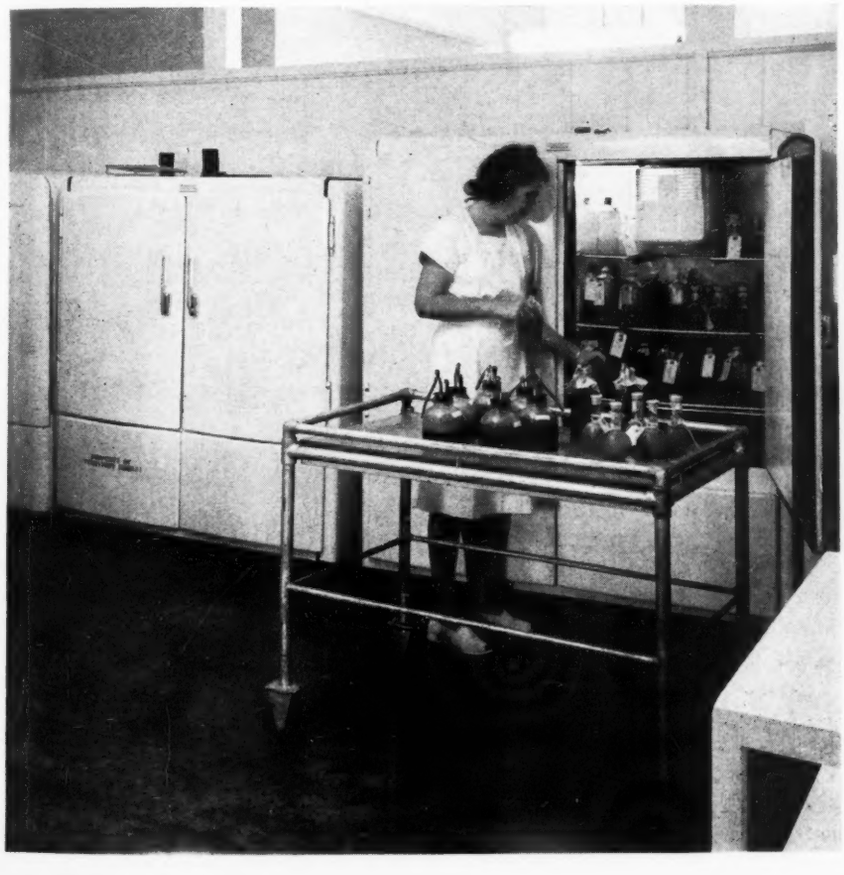


Above: The blood bank is located on the grounds of Queen's Hospital. The building is divided into four departments: administrative; blood drawing room; laboratories, and Red Cross motor and canteen services. Below: The refrigerators in the nurses' workroom, which is next to the blood drawing room.

refreshments by the Red Cross before leaving.

The nurses' work space serves for the cleaning and preparation of their equipment and is readily accessible to the refrigerators where the blood is taken immediately.

These refrigerators form the nucleus of the building. Here is stored a "revolving fund" of blood ready, with blood grouping and serology tubes attached, for any emergency. Each day the fresh blood is put in and the oldest blood is withdrawn for the extraction of plasma. Thus, the Honolulu bank is truly a *blood and plasma* bank and not plasma only.



The plasma laboratory, which is air conditioned, includes alcoves for drawing off and for filtering the plasma and for the cleaning and sterilizing of equipment, in addition to an office alcove for the preparation of reports and special records.

The building is structurally of a temporary nature. The use of all strategic materials was, of necessity, kept to a minimum. The exterior walls are of hollow tile, locally fabricated; the interior partitions of wood are removable for future change of occupancy; the floor is acid-stained cement, and the roof is of wood frame with membrane roofing and canec ceiling.

The window openings are furnished with a sliding wood panel which, when raised, admits light and air for daytime use. At night, this panel may be lowered, still admitting air but, in combination with the hood on the interior and the overhanging eave of a dark color on the exterior, preventing the passage or reflection of any light visible from the air—a vital necessity in blacked out war-time Hawaii.

Raising the Standard of *Anesthesia Service*

GERTRUDE L. FIFE, R.N.
DIRECTOR, SCHOOL OF ANESTHESIA
UNIVERSITY HOSPITALS, CLEVELAND

ANESTHESIA service in the small hospitals, particularly those situated in the rural communities, presents a more difficult problem than it does in the large hospital in a metropolitan area. If modern methods of anesthesia are to be employed, someone must be available who has had special training in anesthesia, and it is this factor that creates the difficulty. We all realize that there is a shortage of personnel in almost all departments in our hospitals today, but even prior to this emergency, small hospitals found it difficult to organize an efficient anesthesia service.

Problems to Be Overcome

Probably the outstanding reasons are: (1) a full-time anesthetist may not be justified from the standpoint of the volume of work; (2) trained anesthetists are usually interested only in anesthesia and object to combination work, particularly general duty; (3) operating schedules may be of such a nature that the efficient, progressive anesthetist might not be attracted to the position; (4) doctors in the community who carry on a private practice may be unable to leave to take special training in anesthesia; (5) the busy doctor finds it difficult to spend his mornings administering anesthetics and he may object to holding himself available for emergency cases in the afternoon and at night.

Recently a questionnaire was sent by The MODERN HOSPITAL to a selected group of 50 small hospitals, all under 85 beds, to see if the procedures now being followed could be interpreted as a trend that might help other small hospitals. The 23 replies received were about as expected and, although no new or startling facts were gained from the answers, the information presented serves as a basis from which to start this discussion.

It was found that 43 per cent of the hospitals surveyed employ nurse anesthetists; in 48 per cent the anesthetics are given by doctors and in 9 per cent they are administered by both doctors and nurses.

Undoubtedly, many more nurse anesthetists would be employed in the small hospitals today if they were available. There is a shortage of doctors in the small communities and it is unfortunate that a doctor must be tied up all morning giving anesthetics when, otherwise, he probably would be making calls and taking care of sick patients. The hospital might consider sending a local nurse who shows special aptitude to take a course in anesthesia. The schools of anesthesia today are willing to cooperate by increasing the student body in order to meet just such situations.

The question was asked: "Who is responsible for the conduct of the anesthesia service?" The results reveal that in 57 per cent of the hospitals physicians or surgeons are in charge; in 13 per cent, hospital administrators; in 9 per cent, nurse anesthetists, and in another 9 per cent, the operating room supervisor.

The "Manual of Hospital Standardization" published by the American College of Surgeons states: "If it is impossible to obtain or maintain a specially trained anesthetist in the community, a member of the medical staff who has had experience in anesthesia might assume the responsibiltiy for supervision and direction of the department of anesthesia." Therefore, it would seem advisable for the hospital to appoint a doctor in the community to assume the responsibility of the anesthesia department.

If there are several surgeons on the staff, a rotating system might be developed in order that not too large a proportion of one man's time would be taken up in this special service. This would also give more than one of the surgeons an insight into the administration of the anesthesia department and the problems involved.

The question of compensation is always important. In the case of nurse anesthetists, 92 per cent of the hospitals compensate the anesthetist in full. In 53.8 per cent of the hospitals in which physicians administer the anesthetics, the anesthetist is not compensated by the hospital; in 7.8 per cent the anesthetist is paid by the hospital; 38.4 per cent did not answer the question in regard to salary. Therefore, it would seem that it has proved more satisfactory for the hospital to compensate the nurse anesthetist entirely and, in the case of the physician, to let him make a direct charge to the patient.

Hospitals Charge Patient

It was also found that when the nurse anesthetist is employed and compensated by the hospital, the majority of the hospitals make a direct charge to the patient for anesthesia service. One hospital includes the cost of anesthesia in the operating room charge, and 30.8 per cent of the hospitals make no direct charge to the patient. When physicians give the anesthetics, again 30.8 per cent of the hospitals did not answer the question, but from the answers obtained it was found that it is customary in most instances for the physician to bill the patient direct. In fact, only 15.4 per cent of the hospitals employing physician anesthetists make a direct charge to the patient for anesthesia service.

It is my feeling that if a nurse anesthetist is employed she should

be compensated in full by the hospital. In the instance of a physician the arrangements must be made between the doctor who gives the anesthetic and the hospital administration. If any anesthetist gives an anesthetic and collects the fee, however, the hospital should be reimbursed in some way for the use of the equipment and the drugs if they are furnished by the hospital.

We found that every hospital surveyed furnishes the anesthesia equipment. Rather than make a direct charge to the patient for the use of the equipment it would seem advisable to include this in the operating room charge.

Only 15.4 per cent of the hospitals take the responsibility of obtaining an anesthetist when the surgeon wishes to operate. In other words, when the surgeon brings a patient into the hospital, in the great majority of the smaller institutions the surgeon or the attending physician is responsible for seeing that the anesthetist is available.

We asked the question: "If the nurse anesthetist is required to perform duties in the operating room other than anesthesia, what combination have you found most satisfactory?" Various answers were received, such as: "x-ray and laboratory —also pharmacy"; "central supply"; "general nursing"; "supervision and bookkeeper"; "clinic and plaster room"; "buying, collecting, bookkeeping, x-ray technician, general floor duty and superintendent"; "x-ray and administration"; "supervisor of surgery"; "superintendent of nurses"; "floor supervisor." Not one of them included record room.

It is the unusual small hospital that does not find it imperative for the nurse anesthetist to be assigned other duties in addition to anesthesia. Regardless of what other work is assigned to the anesthetist, it should be such that she will be free at any time to report to the surgery. It is unfair to the patient, and to the surgeon and the anesthetist, for an anesthetist in the midst of giving a bath, for example, or making rounds with the doctors to be forced to leave such duties to give an anesthetic.

It so often happens under these circumstances that the anesthetist is hurried in getting an anesthesia started and she does not have an opportunity to talk to her patient; the surgeon may be irritated because he has had to wait, and the whole situation builds for poor service.

X-ray and laboratory work and record room work seem to me to be the combinations that would be most suitable. The record room is an extremely important department. The anesthetist, of course is familiar with medical terminology and in the instance of the surgical case she has followed the patient's progress for days. I think an excellent job might be done by the anesthetist in the record room.

If a nurse anesthetist is employed, some arrangements must be made for her to have sufficient time off duty to keep her happy and in good physical condition. She should not be expected to take calls day and night, week in and week out. It is fortunate if there is another nurse in the institution who can give the anesthetics when the anesthetist is off duty. From the replies received it is apparent that in most small hospitals the anesthetist is on call most of the time.

For example, one hospital made this reply: "Surgery limited to about six majors a month, therefore anesthetist has a fair amount of free time; on call at night." The anesthetist is entitled to definite hours of relaxation and unless this is taken care of it will become increasingly difficult to find people to assume the responsibility of anesthesia in the small hospital.

THIS MONTH'S CORRESPONDENTS

HOSPITAL	SIGNED BY	BEDS
Morton Plant Hospital, Clearwater, Fla.	Lilly C. Foley	50
Rehoboth Mission Hospital, Rehoboth, N. M.	R. H Pousma, M.D.	30
Colchester County Hospital, Truro, Nova Scotia	Jean S. Paterson	60
Memorial Park Hospital, Caldwell, Ida.	Peg Milliner	20
Proctor Hospital, Proctor, Vt.	Helen B. Wood	33
Valley Hospital, Tremonton, Utah	E. H. White	20
St. Mary's County Hospital, Leonardtown, Md.	Ethel Van Camp	35
Bishop Randall Hospital, Lander, Wyo.	Mrs. Elizabeth Hainworth	26
Community Hospital, East Tallassee, Ala.	Martha Dunn	27
Grace Hospital, Inc., Morganton, N. C.	S. K. Hunt	82
Alexander Blain Hospital, Detroit, Mich.	Mrs. Anne Catlin	60
New Jersey Orthopedic Hospital and Dispensary, Orange, N. J.	Cora E. Gould	34
Natchitoches Hospital, Natchitoches, La.	Marie Cole	30
St. Francis Hospital, Burlington, Iowa	Sister M. Candida	50
Mercy Hospital, Durango, Colo.	Sister M. de Lourdes	45
Lourdes General Hospital, Campbell River, B. C.	Sister M. Barbara	55
General Hospital of Monroe County, East Stroudsburg, Pa.	Harry J. Smith	65
Highland Park Hospital, Highland Park, Ill.	Marjorie M. Ibsen	55
Harrison Memorial Hospital, Cynthiana, Ky.	Mrs. Mayme McMurtry	35
Alexander-Eastman Hospital, East Derry, N. H.	Mrs. Dorothy L. Rounds	21
Gibson General Hospital, Princeton, Ind.	Mrs. Dolores Lutz	31
St. Luke's Hospital, Fergus Falls, Minn.	Emil C. Hansen	52
Cornwall Hospital, Cornwall, N. Y.	Lee B. Mailler	61

In regard to the types of anesthetics used in the small institution, it was interesting to note that the gases are available today. In 65.2 per cent of the hospitals surveyed nitrous oxide is used in combination with other drugs. In 17.4 per cent ethylene and cyclopropane are also available. In 65.2 per cent of the hospitals the intravenous anesthetics are now being used.

This study indicates that the small hospitals are conscious of the development of the new anesthetics and that they have taken steps to provide modern methods of anesthesia. These drugs cannot be administered except by trained people; therefore, one can assume that the anesthesia service in the small hospital is on a much higher plane than formerly.

There are a great many hospitals throughout the country with a bed capacity of 100 beds or less; therefore, the service given by the small hospital is an important factor in maintaining the health of our people. The large institutions must cooperate by encouraging nurse anesthetists to locate in the small community, and the schools of anesthesia should accept special students from these communities when possible.

This is the only way in which the standards of anesthesia will be raised and the small hospital will be equipped to give efficient anesthesia service to the great number of people who live in rural areas.

BOSTON

Rain failed to dampen the enthusiasm of the crowd that gathered to see 260 students, representing 26 schools of nursing, march across historic Boston Common to the mass capping ritual.

Here's How They Celebrated National Hospital Day

In Massachusetts
In Pennsylvania
In Missouri
In Michigan
In Illinois

IN SPITE of overcrowded hospitals and inclement weather the 1943 National Hospital Day observance set several marks. Reports of unusually good programs are available from Missouri, Massachusetts, Michigan, Pennsylvania and Illinois as we go to press.

Most Hospital Day programs centered around nursing and nurse recruitment although the Pennsylvania program was keyed to war-time nutrition.

The highlight of the Massachusetts program was a mass capping exercise on Boston Common with 260 students representing 26 nursing schools in the metropolitan area. Although umbrellas were frequent through the audience, a large group assembled to see the ceremony and hear the notable list of speakers, including Governor Saltonstall, Acting Mayor Hannan, Gen. Sherman Miles of the First Service Command, Capt. Herbert L. Kelley, medical officer of the First Naval District, and Eleanor P. Bowen, supervisor, state board of registration in nursing. Dr. Charles F. Wilinsky presided. Music was provided by coast artillery and Navy bands and the program was broadcast over a Boston station.

Recruiting booths for student nurses were set up for the week in all Greater Boston high schools.

In addition to participating in the capping ceremony, near-by Newton Hospital observed the day with the formal opening of a new x-ray department.

Three unique events featured the celebration in St. Louis.

The first was a special memorial service on May 10 at Soldier's Memorial when a former governor, Henry S. Caulfield, placed a wreath on the cenotaph honoring nurses and doctors in the armed forces and hospital workers at home. Participants in the ceremonies included Waacs, Waves, Spars, Marines, Army nurses, graduate nurses from 23 St. Louis hospitals, student nurses, Red Cross nurse aides, other hospital volunteers, soldiers, sailors, coast guards, veterans' organizations and medical societies.

The importance of hospital workers in war was emphasized by an impressive ceremony on May 12 before the new St. Louis County Health Center on the grounds of the St. Louis County Hospital. A

ST. LOUIS

parade of 700 marched from the county court house to the hospital grounds. Workers from all departments of St. Louis hospitals marched with men of the armed forces, county officials and hospital administrators.

Lt. Col. J. G. Kruml of the U. S. Army Medical Corps, Lt. R. R. Barnam of the Navy and Lt.-Col. Curtis H. Lohr, director of the county hospital, who will soon depart for active duty as head of Base Hospital 70, decorated the hospital workers with the A. H. A. "essential worker" pins.

Principal speakers were Dr. Frank R. Bradley, Rev. A. M. Schwitalla, S.J., Bishop John C. Broomfield and H. J. Mohler.

The third feature was the presentation by the St. Louis Hospital Council of its first annual Community Service Award to the Rotary Club of St. Louis for its efforts in recruiting and financing student nurses. The club originated its program in July 1942 and now has 100 nurses in training. Adopted by Rotary International, similar programs are in effect in several cities.

The award was made at the regular Thursday luncheon on May 13 in the presence of many foreign notables assembled in St. Louis for the convention of Rotary International.

Hospital Day activities began early in Erie, Pa. On May 3 groups of 18 high school pupils visited each of Erie's six hospitals. They then wrote 1000 word reports. Prizes were given for the best reports, which were also published in the school paper and the city newspaper and were broadcast over local radio stations. Each pupil put on a mask and gown before visiting the children's ward, operating rooms and maternity floor.

On May 12, Hamot Hospital entertained about 150 student nurse applicants and the American Red Cross held a nurses' rally.

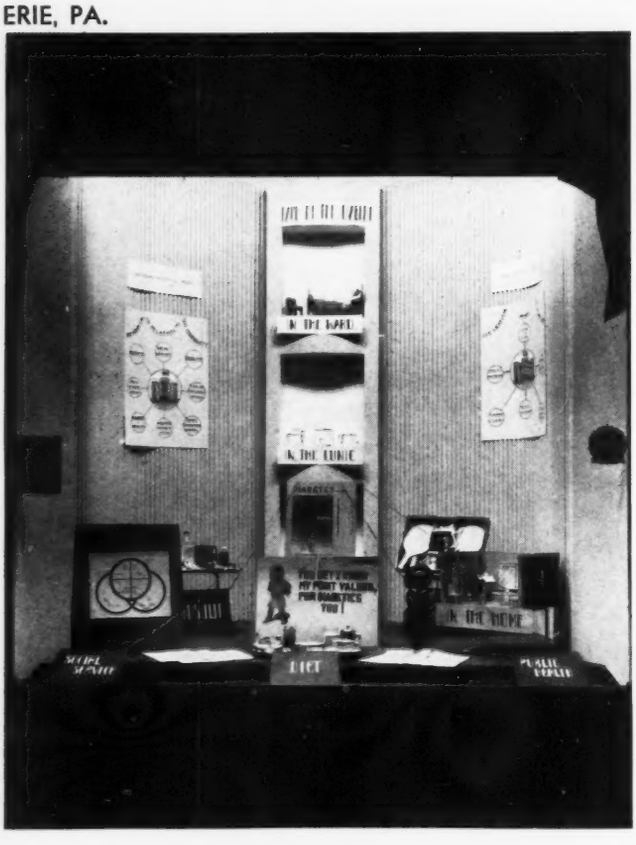
C. Rufus Rorem was the featured speaker at the Erie observance, speaking before the high school, Rotary Club, a joint meeting of women's auxiliaries of the six hospitals and on a radio round table with the presidents of the boards of the six hosptials.

A diabetic program was offered three times by Hamot Hospital with a capacity crowd at each session. In addition to demonstrations, lectures and motion pictures on diabetes, there was at the hospital a large exhibit of foods, with posters and literature. This was in accord with the state association's emphasis on nutrition.

Radio played a large part in the Michigan celebration with 12 broadcasts during the week, including one by Mayor Jeffries of Detroit. A big nurses' rally was held on May 10 and on May 12 several nurses were sworn into the Army at a public ceremony at Grand Circus Park. Military officers, local officials and prominent nurses participated.

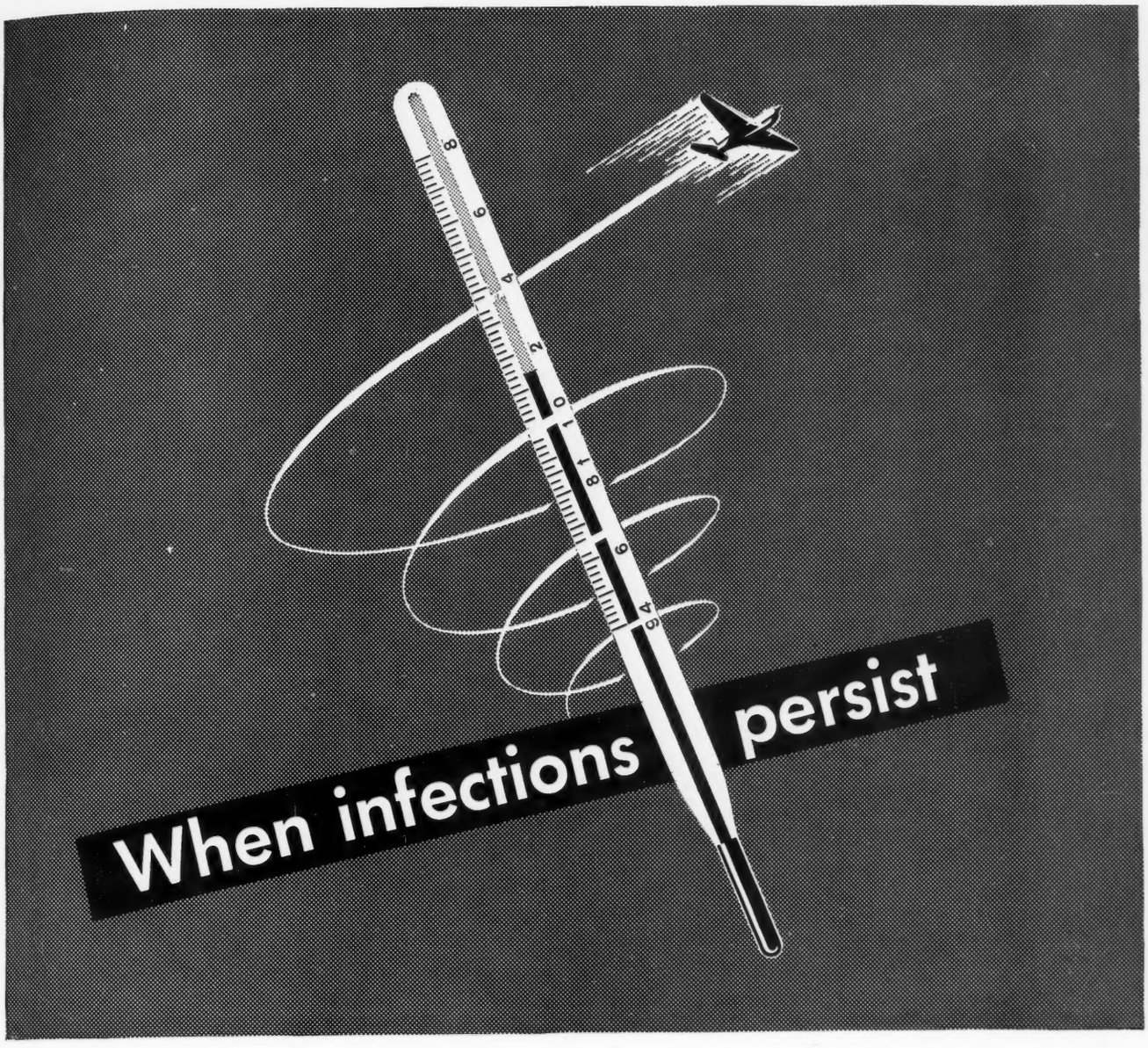
In Chicago, Children's Memorial Hospital held an open house, with a tour of the clinic building and nurses' residence. A highlight of the tour was an exhibit of pediatric antiques lent by Mead Johnson and Company.

ERIE, PA.



Above: Hospital workers assembled before the new St. Louis County Health Center to hear Dr. Frank Bradley bring greetings from the A.H.A.

Left: At the celebration at Erie, Pa., the emphasis was on nutrition, with a large exhibit on foods. A diabetic program was given at Hamot Hospital in Erie.



When infections persist, careful study for symptoms of adrenal cortical insufficiency should be undertaken. The patient may show unusual asthenia and pronounced hypotension, in addition to low resistance to exposure and strain.

ADRENAL CORTEX EXTRACT (UPJOHN) is a potent specific therapy now available for increasing resistance, muscle tone and capacity for work in adrenal cortical insufficiency.

Adrenal Cortex Extract (Upjohn)

Sterile Solution in 10 cc. rubber-capped vials for subcutaneous, intramuscular and intravenous therapy

Upjohn
KALAMAZOO, MICHIGAN

ANOTHER WAY TO SAVE LIVES . . . BUY WAR BONDS FOR VICTORY

We Must Look to the VOLUNTEER

It is no longer a case of what to do with volunteer helpers but where to find more! The Chicago Hospital Council reveals its findings on the volunteer workers already serving in Chicago hospitals, the number still needed and the scope of their duties

VERONICA MILLER, R.N.

SUPERINTENDENT, HENROTIN HOSPITAL, CHICAGO

IF HOSPITALS are going to maintain even minimum service during this war period, all available sources of help must be used and we must look for help principally from volunteer workers. A recent study by the Chicago Hospital Council reveals some interesting conclusions, as follows:

1. Fifty Chicago hospitals now employ a total of 2500 volunteers.
2. The scope of work that may be delegated to them has broadened greatly.
3. At least 500 more volunteers are needed at the present time. The most urgent needs are for more Red Cross nurses' aides and for canteen workers.
4. Good orientation programs and supervisory control of volunteers make for more efficient service.

85 Per Cent Use Volunteers

Approximately 85 per cent of the reporting hospitals are now supplementing their personnel by volunteer workers from various agencies and with their own volunteer groups. The number of workers varies from five to 200 to a hospital. They serve for periods varying from two hours once a week to four or five days a week and at any time from 8 a.m. to 10 p.m., according to the particular hospital's schedule.

Programs for recruitment of volunteers are still expanding in view of the high turnover of both paid and volunteer workers. Hence, the number of volunteers may need to be doubled during the coming year.

Recruits have come from the American Red Cross, women's auxiliaries, American Women's Voluntary Services, Y.W.C.A., Girl Reserves, churches, high schools, clubs, council of social agencies, the Office of Civilian Defense and interested individuals.

The scope of the work to be done by volunteers has broadened decidedly since Pearl Harbor. No doubt the greatest single recent contribution to hospital service has been the introduction of Red Cross nurses' aides, canteen workers and Gray Ladies. By far the greatest help is given by the trained volunteer. The Red Cross program has been a bulwark to the nursing service of our hospitals. It is fortunate that it is now so recognized. It may stimulate other organizations to concentrate their energies in similar channels.

According to the results of the survey every department of the hospital except the power plant is in need of volunteer help; 24 specific departments were mentioned. Heading the list of essential workers were nurses' aides, canteen workers, clerical help, bandage makers and housekeeping assistants. The administrator of one hospital that already has 150 volunteers says that more are needed in all departments.

The question for hospitals is no longer, "Can we use volunteers?"—but, "Where can they be obtained?"

The use of men volunteers has been discussed but as yet no program for them has been outlined in Chicago. Much assistance might be obtained from boy scouts, the Y.M.C.A. and men's service clubs. There are lawns to be cared for, window screens to be put up and victory garden projects. In some cities men are acting as orderlies, clerks, maintenance men, elevator operators, ambulance drivers and even watchmen.

More Will Be Needed

The need for workers will multiply as the war goes on. The labor market is being rapidly depleted. Owing to the high turnover of volunteers, large additional groups will need to be interested in order to maintain even the present supply.

The American Women's Voluntary Services, a national group with 500 units in 30 states enrolling more than 250,000 women, organized a branch in Chicago last September. It has achieved noteworthy success in recruiting women from all ranks, especially among capable business girls. Here is a productive source for help in departments of the hospital other than nurses' aides. The patriotism of these women runs high; a great many volunteer to work at least one or two evenings a week, Saturday afternoon or several hours on Sunday. Many express preference for work in hospitals and

more than 200 are so engaged in Chicago. Administrators who have obtained workers from this group find that they have amply filled positions of floor clerks, typists, stenographers, telephone operators and many other vacancies.

Women's clubs are also interesting their members in hospital volunteer work, as are school, church and neighborhood groups and service clubs.

In most instances an orientation course of lectures is in order for new members. The logical instructors are the hospital administrator and interested department heads. A tour of inspection through the hospital might also be advisable. The groups should be familiarized with medical and hospital ethics.

The problem of control of the workers will vary according to the hospital. The American Red Cross specifically requests that its aides and Gray Ladies be assigned directly to the nursing department. Most authorities agree that this is wise. For other workers, many hospitals are engaging full-time directors of volunteers. The amount of detail and instruction necessary makes such a director a decided asset.

The introduction of large numbers of volunteers is a new departure in most of our hospitals and should have close attention during its initial stages. The work done by this group is of inestimable value right now. Its future value depends largely on the smooth functioning of present programs. War conditions may force us to make some changes that will be permanent.

Frequently, the regular employes of the hospital need an orientation course as to their responsibility and attitude toward the newcomers. With an acute shortage of regular help, employes' nerves often become frayed and taut. They may not realize the help that a volunteer will give. The additional task of instructing others in their own work is discouraging. Now, more than ever, group meetings are in order.

The patriotism of hospital employes is as high as that of other groups. If they are properly informed of the reasons for new procedures, they will carry their full share of responsibility. A wholesome influence permeates an organization when workers come in from the outside and give freely of their time.

One of the directors of a volunteer agency expressed gratitude to the Chicago Hospital Council for its survey because it brought to the attention of the public the great need for volunteers. Few people realize how trying it is to spend long hours interviewing and soliciting recruits day after day. This is a patriotic service from which hospitals have benefited. Appreciation of the work of these agencies and recognition of individual workers will stimulate more interest in hospital service.

What should these volunteers wear? Smocks or some simple uniforms should be recommended and possibly some kind of pin in recognition of service. Head gear similar to that worn by Red Cross workers may be necessary for those working on patients' floors or on surgical supplies. High heels are to be worn only at the risk of the individual.

The limitation of transportation makes it impossible for many willing workers to continue. A volunteer may be willing to work in the hospital of her choice but not in another. Unless this difficulty can be overcome, much profitable service may go into other channels or be lost entirely.

Help is badly needed in many hospitals. The volunteer is not the whole answer. Acute shortages of help over a prolonged period will take a toll on any group of employes but an army of volunteers is a powerful bolster for morale in the face of such conditions. They can relieve employes of tedious detail and help create a new and more optimistic spirit.

Encourage your volunteers and the agencies from which they come. They are the hope of the hospital field today.

WOMEN'S SERVICE GROUPS

On the Iron Range

Any venture succeeds that fills a real need. The 10 year old auxiliary of St. Luke's Hospital, Marquette, Mich., had served the hospital well from its inception by staging the usual money-raising dances, card parties, teas and garden walks.

Then came the war, bringing an unexpected situation to this isolated community in the Iron Range country. Marquette became the induction board center of that section. The prospective draftees had a long route to travel from the Upper Peninsula to the Army and Navy medical examining officers who were stationed on the other side of Lake Michigan.

Last November the Army and Navy started to come to Marquette rather than have the future inductees travel to them. That meant that 100 Army men and 40 Navy men were at the hospital during the day.

Now St. Luke's Hospital is a long way from the downtown hotels. The winter's cold was terrific; the roads were icy and transportation was both a hazard and a discomfort.

To serve these 140 men the women's auxiliary set up a canteen; Mrs. Hazel Youngquist, a graduate home economist, was the natural choice as its director. Everything was planned to meet the desires of the Army and Navy personnel. The doctors liked to get an early start on their examinations so they wanted breakfast at the hospital. They get breakfast, all 140 of them. They also get lunch at the canteen.

At first, it was sandwiches, coffee and fruit juices chiefly. But the men wanted hot soup so one auxiliary member makes 6 gallons of soup each day during the five day week. The chicken noodle soup that one member makes is so delicious that it is always a quick sellout.

Naturally, the project took some maneuvering. It was necessary to apply to the food rationing board under the institutional classification, but the application was promptly granted.

Volunteers do every bit of the canteen work and their reward is not only the great gratitude of the Army and Navy patrons of the canteen but a sizable monthly profit. It averages $100 a month. Naturally, the hospital is the beneficiary.

Out of this neat sum, the auxiliary voted the expenses of its alert president, Mrs. Arthur K. Bennett, a staff doctor's wife, to the Tri-State Hospital Association meeting in Chicago, May 5 to 7, to learn what other auxiliaries are doing.

To make the Army and Navy men feel at home in Marquette, the auxiliary has given four dances during the winter in the recreation room of the beautiful nurses' home. This is not a money-making scheme, just a contribution to military, naval and nurse morale.

TRUSTEE FORUM

The Situation Calls for CENTRAL PLANNING

ARTHUR A. BALLANTINE

VICE PRESIDENT, UNITED HOSPITAL FUND
PRESIDENT, THE GREATER NEW YORK FUND

IT IS heartening in this time of total war that we think and plan not merely for a saved world but for a better world. Here, as in England, we rightly give thought to forward-looking social plans, however preliminary and tentative they may be at this stage.

For the community health program of the future, the hospital is the very foundation. With the remarkable advances in science and in social living the function of the hospital has vastly expanded.

How Hospitals Have Changed

At first, hospitals were convenient places for the treatment of the sick, the service of the doctor, the relief of the home. Now they are much more—the means of concentrating a richness of medical knowledge and technics that in many cases could never reach the home. They are centers for research that has greatly relieved or almost banished many of the most dire physical ills. They furnish indispensable facilities for teaching physicians, surgeons and nurses. Their out-patient service makes their resources available to millions who otherwise would have wholly inadequate medical advice and treatment.

What is the part of the voluntary hospital in the broadened and improved health program of the future?

Voluntary hospitals throughout the country owe their origin to private benefactions. While they derive their current support in large measure from patients who have ability to pay for their service, in whole or in part, their maintenance still requires continued voluntary giving. They are operated under trustees who donate their time and thought. Their service to the public is recognized by tax exemptions and, in many cases, by some measure of help from public funds for their care of patients who cannot pay.

Little need be said here about the value and extent of the services that the voluntary hospitals have rendered and are rendering to our people; they have been indispensable. We have heard of their foresighted and generous response to the war call; of the brave units of nurses and doctors going out from them to the far flung battle fronts; of their plans for the care of the wounded and of those who might suffer here through invasion from the air.

Research Goes On

We know, too, that in spite of the heavy war claims on the personnel and the sharply increased costs of operation, their great work of caring for the civilian population, of training new doctors and nurses and of ceaseless research goes on unabated. Needless to say, there has been no abiding answer to their ever-present financial problem.

In addition to the voluntary hospitals we have municipal and state hospitals and now federal hospitals. The federal hospitals even now are not exclusively military and after the war may be available, in part at least, for civilian purposes. While voluntary hospitals were in many cases earliest in the field, today, in Greater New York, as elsewhere in the country, most of the care of the chronically ill and the mentally ill is given in city and state institutions. Apart from patients in state and federal hospitals, the voluntary hospitals care for most of the acutely ill bed patients who pay part of the cost and for about a third of those who cannot pay at all.

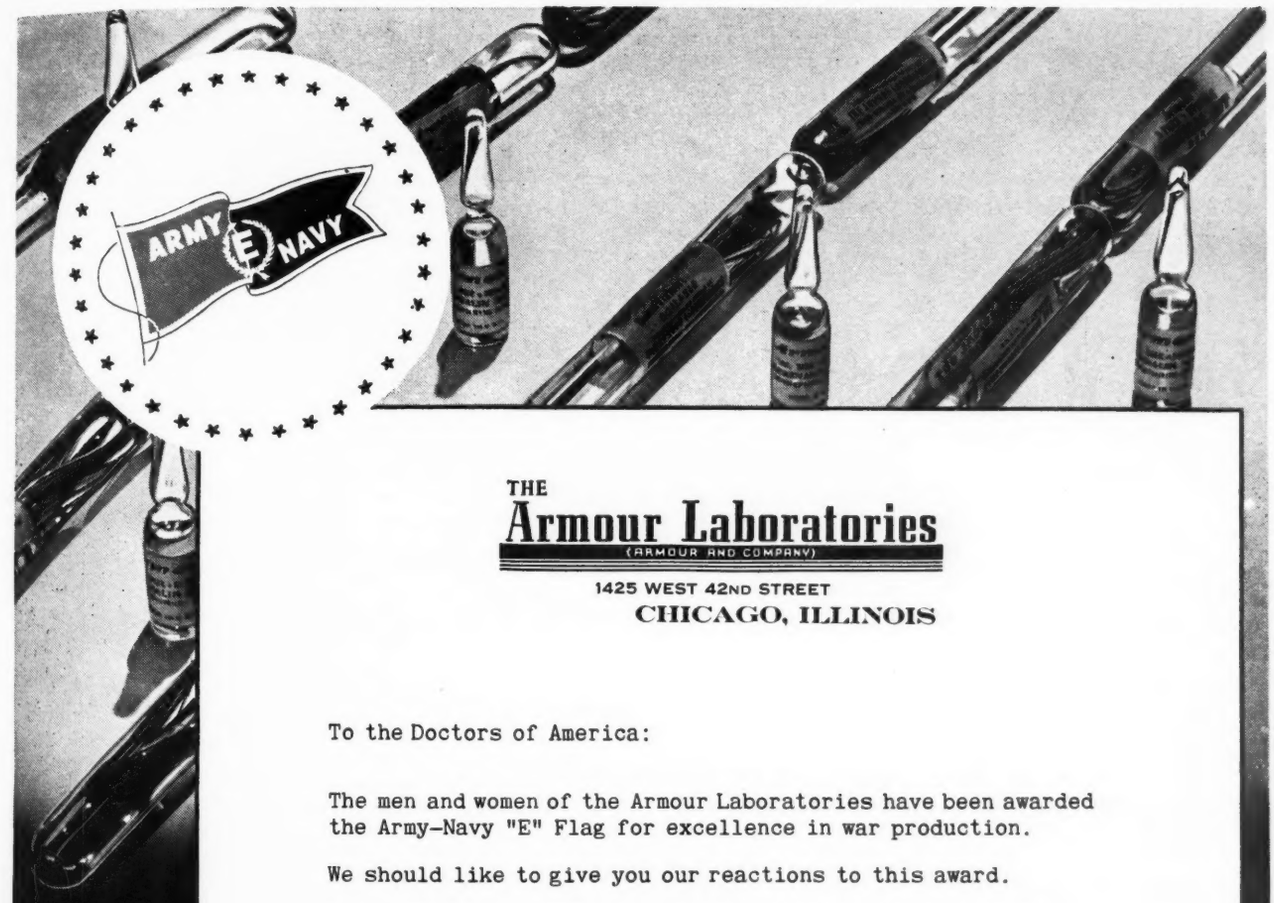
In order to give assistance in the service of those who cannot pay, the hospitals in New York receive substantial, although not adequate, help from the city. For out-patients, the voluntary hospitals carry on almost two thirds of the service and this without financial assistance from the city.

Voluntary hospitals rightfully conducted and managed have a vital part in the large physical welfare program of the future. The only alternative would be to have the work of these hospitals taken over by government agencies. With expanded reliance in so many fields upon government activity, that possibility in this field is one that must certainly be discussed.

If the Government Takes Over

The assumption of the services of the voluntary hospitals by governmental hospitals would involve irreparable loss. The physical plants of the voluntary hospitals could, of course, be taken over by the government. Indeed, most of them would have to be utilized unless great values were to be thrown away. However, the taking over of the voluntary

From a talk given at the symposium, "Civilian Hospitals in War Time," March 30, New York City.



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To the Doctors of America:

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First of all, we of The Armour Laboratories staff are keenly proud of this honor. We consider it the most significant honor that any American organization can receive today.

Secondly, we know that this award carries with it a very great responsibility. A responsibility to the medical corps of both the Army and the Navy....and through them to the American fighting men on every front.

Stated very simply, our assignment is to supply the Army and Navy medical corps with those Armour Laboratories medicinals which they need to help save the lives and restore the health of Americans in uniform. To supply the needed medicinals in the amounts required, at the time specified.

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The Staff of the Armour Laboratories

hospitals by the government would be an intolerable wrench to those who have built them up and cared for them. In many cases it would be like tearing tissue from a living body, yet the physical plant and, perhaps, in a large measure, the devoted staffs could be taken, although there again would be distress and impairment of devotion and loyalty.

To give up or displace the voluntary hospital would be to deny scope and opportunity in one of the most appealing of all fields to the expression and practice of freely accorded individual benevolence. The voluntary hospitals are spontaneous associations for human service.

We can be and are supremely devoted to our government. We are ready to fight for it, but we do not give to it—we pay taxes to the government. Only a few can feel the same spiritual satisfaction in doing for the vast mechanism of government that they feel in participating and doing directly for their fellows in distress.

Our great common agency for the relief of suffering and distress in emergencies is the Red Cross. Having the sanction of the government, the Red Cross is still not a government agency. It sprang from benevolence and is maintained by benevolence. No thoughtful person would change that. And who would deny to the individuals on the home front personal participation in the relief of physical suffering, personal part in giving of that relief; who would lessen freedom in that field for the forces of religion and brotherhood that live in these voluntary hospitals?

The need of continuing scope for benevolence is a spiritual consideration, a consideration of utmost importance. But the practical values in the voluntary hospitals weigh only a little less heavily in the scale.

Danger in Overinstitutionalization

Voluntary hospitals give the elasticity and spring needed in the machinery for protecting physical welfare. Governmental hospitals can be, and often are, superbly administered and the achievements of many have been of the first order. Yet governmental hospitals tend to become overinstitutionalized. We see that in other phases of government service.

The voluntary hospitals, on the other hand, are freer to continue to experiment, to meet new needs, to develop new lines. Voluntary hospitals, with the help of devoted women, have been leaders in the development of that indispensable means for the full treatment of many patients, *i.e.* medical social service. The very existence of these hospitals also enables the government to plan more freely and to adjust itself better to changing conditions.

In addition to their actual achievements in fostering new developments and in relieving governmental hospitals, voluntary hospitals serve to supply indispensable yardsticks of efficiency. We have heard of yardsticks chiefly as checks upon private enterprise, but they are certainly as valuable as tests of government enterprise.

A further practical advantage of the voluntary hospitals is their value in calling continued attention to hospital costs. This may seem a surprising point, for hospitals always have a difficult time with costs. Yet, so long as we have voluntary hospitals in the field, that cost question will be before us. If we leave hospitals wholly to the government, it will tend to be overlooked as is the cost of the post office or the police. Although the idea is abroad that in the new world government costs will not matter, I venture to predict that we shall still have to reckon with that question if we attain and retain social salvation.

Recognition Must Be Earned

Voluntary hospitals are not going to take or retain their rightful place automatically or without effort. The effort needed for the assurance of the full contribution of potential values is not a matter of argument. It is a matter of performance.

There are two conditions, at least, to the beneficent future of the voluntary hospital: (1) the hospital must demonstrate its efficiency, and (2) it must demonstrate ability to cooperate in a rounded, over-all program.

Those demonstrations demand unremitting work and open-mindedness on the part of trustees and those responsible for these hospitals. Every voluntary hospital board and managerial staff strive for efficiency. But if we think we have fully achieved that goal, let us refresh our minds with, for example, such an objective study as "The Hospital Survey for New York" made at the instance of the United Hospital Fund and published in 1937. That survey ascribed to our voluntary hospitals an indispensable place but it also set forth many points for further achievement by them, individually and collectively.

Each voluntary hospital tends to be a bit too much of a world in itself. Over-individualization is as much of a danger as over-institutionalism. In New York we make a constant effort to interchange information and the benefit of new developments through the Greater New York Hospital Association, made up of hospital administrators. I think trustees should do more to inform themselves fully on the activities of that useful body and to see that all the possibilities opened up are actually realized.

We Must Plan Together

For a rounded program voluntary hospitals must plan together and plan with state and municipal authorities. Here in New York we have long had effective cooperation in the always insistent problem of fund raising through agencies of the United Hospital Fund, the Jewish Federation, the Catholic Charities and the Greater New York Fund. In spite of earnest efforts, we have not yet achieved sufficient vitality in central planning. The objects of the planning are apparent: to eliminate or merge institutions that no longer serve a useful purpose; to provide for future needs adequately and without overlapping. We now have machinery for such planning but it must be activated by greater energy.

Central planning means attention by trustees to something more than the immediate activities of their own institution. In some cases there must be willingness to sacrifice that individual institution for the larger plan. Yet only through central planning can public confidence be fully deserved and the public need be fully served.

This time of change calls for new dedication of the guardians of the voluntary hospitals to their trusts. Only through increased devotion will the hospitals' full service be achieved and their place realized in the rounded public health program of the future. Not to accord that devotion would be to sacrifice one of the best fruits of freedom and a mainspring of its continued vitality.

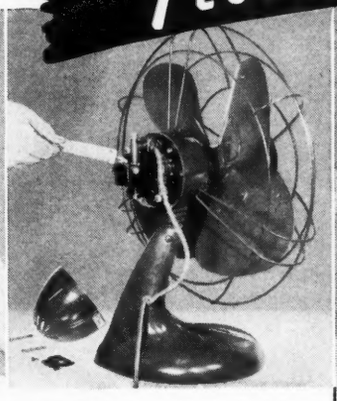
Make your Fans Last..

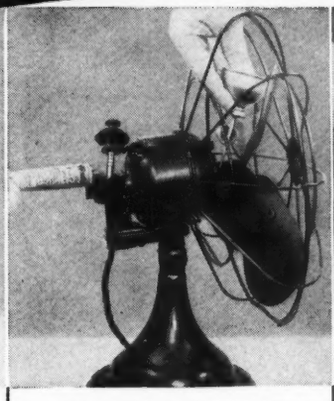
DO THESE THINGS

1 LUBRICATE

STREAMLINE TYPE

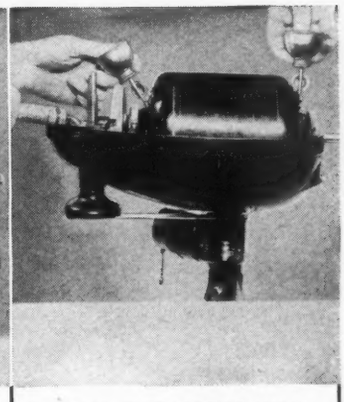
Oil or grease front bearing. Grease gears and rear bearing.





CONVENTIONAL TYPE

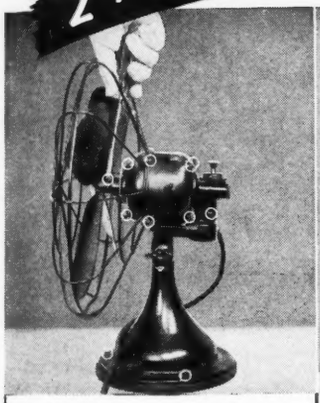
Grease oscillating gears and rear bearing. Oil or grease front bearing.



LARGE CIRCULATOR TYPE

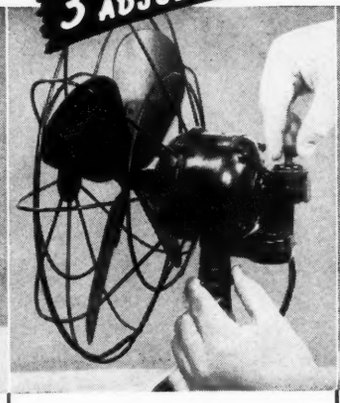
Oil motor at both ends. Grease the oscillating gear.

2 TIGHTEN



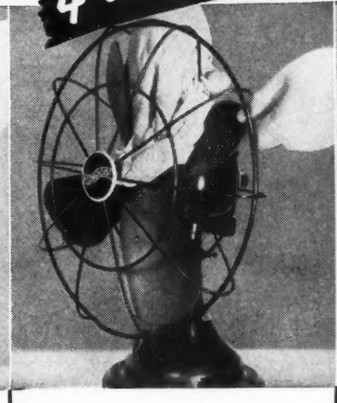
Tighten set screw in fan blade hub. Also tighten screws or nuts holding fan guard, motor case, and other parts.

3 TEST ADJUSTMENTS



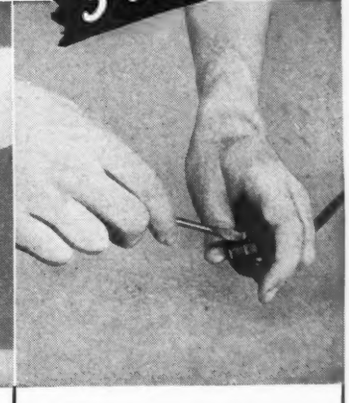
Always loosen clamping screws for directional adjustment. Never force by twisting guard.

4 CLEAN BLADES

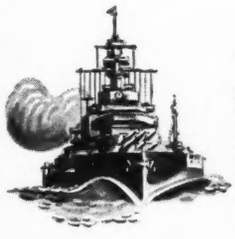


Accumulated dirt and dust cause blade unbalance, vibration and bearing wear.

5 CHECK CORD



Make sure wires are not loose, particularly in plug end. When turning fan off, use switch instead of jerking out plug with cord.



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Westinghouse is now producing more fans than ever—all for shipboard use by the Navy and Maritime Service. With this experience added to an already outstanding record, Westinghouse postwar fans will set a new and higher standard of value.

Always follow the manufacturer's printed instructions. If not at hand, obtain from distributor or manufacturer. Medium-grade machine oil is generally recommended for fans. The distributor or manufacturer will advise what grease to use. Grease for Westinghouse fans can be obtained through your nearest Westinghouse distributor.

Westinghouse *long-life* Fans

Heat Load Increased; Fuel Consumption Cut—Modernization Did It

HARRY H. ANGUS

CONSULTING ENGINEER, TORONTO, ONT.

TORONTO WESTERN HOSPITAL, Toronto, Ont., was founded in 1896 and started as a very small institution. Its growth was gradual for some years but after it united with another hospital in 1925 it developed much more rapidly.

In 1935 the hospital had accommodations for approximately 300 patients. During that year a large extension was started, which was completed in 1936. This consisted of a new 14 story pavilion and several additions to existing buildings. This brought the total accommodation for patients up to 515 beds, with a staff of 200 nurses and 240 lay employes. Before the extension the internal cube of the buildings, or the space to be heated, amounted to 1,800,000 cubic feet. There was an internal cube of 1,900,000 cubic feet in the extension, bringing the total cube of the completed hospital to 3,700,000 cubic feet.

The average yearly coal consumption for some years before 1935 was 2500 tons. Since 1936 the hospital has been filled practically all the time and the annual coal consumption has varied from 2600 to 2800 tons with an average of 2700 tons. The hospital is complete in every respect except that the laundry work is done in another location. With the large increase in accommodation the demand for steam for domestic hot water heating, sterilizing and cooking has greatly increased. The boiler plant provides steam for both heating and the utilities. Under these circumstances the slightness of the increase in fuel consumption is most remarkable.

Comparison of two typical years is given below, the first column applying to the original hospital and the second to the extended hospital. Comparisons are made in this case for seven months, from October to April, inclusive. The two coals were tested and the tonnage is on a basis of equivalent Btu. value.

	Original Hospital	*Extended Hospital*
Coal consumed—seven months	1592 tons	1922 tons
Patient days: seven months	60,700	102,400
Degree days per year	7,744	7,411

Estimated extra coal required to produce steam for sterilizing, hot water, for 41,700 patient days, 280 tons.

Particular care was taken in the design and orientation of the new buildings and additions to the existing structures so that the minimum of heat would be required. In the accompanying photograph the new 14 story building is shown in the center. An extra story was added to the ward building at the left and additions were also made to smaller buildings that cannot be seen in the picture. The high building that forms much the greater part of the extension is used mainly for private patients, operating rooms and x-ray departments. The walls were built of insulating blocks and brick facing and lined with 1 inch cork. The windows are double glazed, calked and weather-stripped. The roof was also well insulated.

Careful attention was given to the orientation of the high building in order to derive the maximum heating value from the winter sunshine. About 70 per cent of the patients' rooms have southern exposure.

The principal reasons for the remarkable results achieved in conserving fuel are as follows:

1. Great care was taken in the construction of the new buildings and their arrangement so that the minimum of fuel was required for heating.
2. Much greater efficiency is obtained with the new boiler plant than with the old one.
3. The new building was arranged to obtain the benefit of the winter sun.
4. The new building was fitted with a controlled subatmospheric system of steam heating.
5. The heating system in the old hospital buildings, which had been one pipe steam, was changed to a two pipe vacuum system.
6. The hot water heating system in the nurses' home was gone over and changes were made to obtain uniform heat. With the old arrangement some rooms were overheated with the consequent excessive opening of windows.

The original group of buildings was heated from a central plant. The boiler plant consisted of three horizontal return tubular boilers, two of which were hand fired and one stoker fired. The buildings were heated by steam with the exception of the nurses' home, which was heated by steam passing through a converter. The boilers were low set and the efficiency must have been quite low. No figures were obtained on the operating efficiency of the old plant but it appeared to be operated about the same as are similar plants in other institutions.

When the new buildings were built it was found advisable to place the power plant in a different location, so a new power house was built. The boiler plant consists of two 250 h.p. water tube boilers fitted with underfeed stokers and capable of carrying 200 per cent normal rating continuously. The new power house has an overhead coal bunker and modern methods of handling coal and ashes. It is equipped with new pumps and heaters and was designed for economical operation.

One boiler carries the load at all times, leaving the other as reserve. The boilers are properly fitted with instruments so that the efficiency of operation can be checked at any time. All parts are kept in good repair and the boilers are properly cleaned at frequent intervals.

Engineers' Question Box

Make Rubber Belts Last

Question 38: What must we do to lengthen the life of the rubber belts on various pieces of hospital equipment?—W.D., Ill.

ANSWER: Belts, especially those of rubber composition, may not be replaceable and should be given extra care as a war conservation measure. The following suggestions apply particularly to rubber composition belts. Keep the belts tight enough to prevent slippage but not so tight as to cause excessive wear on bearings. Belts should be just loose enough to permit about ½ inch play when pressed with one finger.

Keep the belts free from grease and oil so that slippage will not result from oily belt surfaces. Oil and grease also cause rapid deterioration of belts. Pulleys must be kept in line with each other; otherwise the belt wears rapidly. If more than two belts are used on the pulleys and one of a set is showing unusual wear, the position of the belts should be shifted. Rotating belts increases the length of service in the same manner as does rotating tires on an automobile.

When replacing belts or rotating them, never pry or force the belts on or off the pulley as this puts a strain on the belt that may break the outer strands. To remove or put on belts, loosen the motor so that they can be slipped off or on easily. Keep belts dry and clean for long life. Wash dirty belts with a mild solution of trisodium phosphate or any good commercial compound and wipe dry. When replacing belts make an effort to get the same make and model as the one being replaced.

When new belts are installed, check them for tightness at the end of the first two or three weeks of operation. They stretch slightly when first used. Tighten the belts by sliding the motor and keeping them tight enough to permit the ½ inch movement.

Some belts contain rubber. Discarded belts should be salvaged for war use.—O. E. OLSON, *chief engineer, Wisconsin General Hospital, Madison.*

Testing for Leaks

Question 25: What test should I use for leaks in the ammonia line? For leaks in the freon lines?—L.M.S., Iowa.

ANSWER 1: *Ammonia Leaks:* A sulphur taper is generally used in locating ammonia leaks. Litmus paper can also be used. The taper is lighted and placed in the vicinity of the leak and, as it is drawn nearer, a white smoke is formed. The nearer the leak, the whiter the smoke.

Freon Leaks: A torch known as a halide leak detector is generally used in locating freon gas leaks. The torch burns with a blue flame. As the gas comes in contact with the flame, a green color is seen, indicating a leak near by. The nearer the leak, the greener the flame.—CHARLES ALBERT, *chief of maintenance, Strong Memorial Hospital, Rochester, N. Y.*

ANSWER 2: To locate an ammonia leak in our system we use a wooden rod 2 feet in length and ½ inch in diameter, slightly split at the end. Into this slit is placed a piece of red litmus paper. The litmus paper is then dampened and passed along our ammonia tank, pipes and valves. The paper will turn blue immediately upon contact with the escaping ammonia gas. This is the safest, easiest and most reliable method of locating these leaks that we have found. However, to use this method it is necessary to exhaust most of the free ammonia gas from the room.

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Codes Provide Line Size

Question 16: What are the usual provisions of plumbing codes for the size of water and waste lines in kitchens and laundries?—W.M., Me.

ANSWER: *Laundry Waste and Water Lines:* Fixture waste lines must not be directly connected to the washer wheel lines. When lines have been so connected the suds from the washer wheels back up through fixture lines and traps and smear the basins with scum. Washer lines should be directly connected to main waste lines. Sizes vary with laundry capacity but no line smaller than 1¼ inch standard galvanized pipe should be used.

The sizes of laundry water lines vary with laundry capacity. In an institution with a turnover of from 2 to 3 tons of dry clothes a day, there is usually a 2½ inch brass water line feeding the washers. A 3 inch cold water line and ¾ inch pipe feeds to fixtures.

Kitchen Waste and Water Lines: For fixtures, 1½ inch standard galvanized waste lines should be used and increased generously, depending on the number of fixtures. Where grease is a menace, lines should be oversized and a large grease trap should be installed. Water lines in kitchens should not be smaller than ¾ inch standard pipe.—CHARLES ALBERT, *Strong Memorial Hospital, Rochester, N. Y.*

LEHMANN WINS $5 AWARD

For her answer to the question: "Why Do Dressings Mildew?" the monthly award of $5 was presented to Emmy Lehmann, central supply room supervisor at Strong Memorial Hospital, Rochester, N. Y.

Do you have the answers to the following questions? If so, jot them down and send them in to the Engineers' Question Box.

34. Our hospital has been heating with oil and we expect soon to change over to coal. Would we do better to use a stoker or a pulverizer?—R.S., Ind.

35. If we install a pulverizer, how can we avoid complaints about fly ash?—R.S., Ind.

HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

Linen Control in War Time

In times of war economical adjustments in all phases of work affect the people at home. The ability to save has become their contribution to the fight and hospitals, as an integral part of the home front, must fall in line. Departmental functions should be reviewed and analyzed with an eye to savings.

Among the hospital's assets the linen stock, which represents a sizable investment of its funds, needs now, more than ever, the protection of a revitalized control system.

Linen control today must adapt itself to prevailing conditions which require the obtaining of priorities for the purchase of many linen items without any guarantee that these can be acquired in the market. No predictions can be made in regard to the life expectancy of any particular piece of linen inasmuch as it may be necessary to double or even triple its life owing to the conditions.

No longer is it possible to point with pride at the daily flow of freshly laundered linens that are part of the service given to patients — private and ward alike. No certainty exists that replacements will be forthcoming in time and the future efficient operation of the linen service depends on the ingenuity with which adjustments are made. Methods of conservation must be found and put into practice without delay. Careful study should be given to the advisability of reducing existing linen quotas.

Many steps have been taken in recent months by the hospitals to cut expenses, and many services that only a short while ago seemed indispensable to their operation in other fields have been suspended. The same reasoning should be applied to the linen and laundry problem.

If, for instance, bed linens are still being changed daily on all hospital floors, regardless of the patient's condition, certain days should be set aside as bath days with complete changes taking place on these days alone.

With the cooperation of our nursing department we have instituted such a plan at Beth-El Hospital, Brooklyn, N. Y. Three days a week have been chosen as bath days. On all intervening days only sufficient linens to take care of new admissions, transfers and incontinent patients are furnished. The control system, however, does take into account a daily change of draw sheets and patients' gowns.

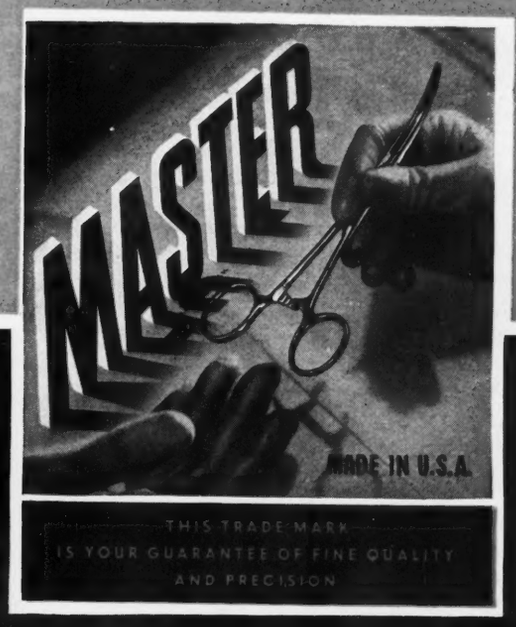
No reductions have been made in the quotas of operating rooms, delivery rooms, nurseries and kitchens, which continue to receive full allowances. Few complaints have been received by patients who were informed tactfully that the present situation requires stringent economies in the use of critical materials.

This part of our linen conservation program has been a great success. Real economies have been achieved by reducing supplies and working hours in the laundry and on the floors among the nursing personnel and, most of all, a decided reduction in the turnover of linens has taken place.

At the same time, we have reviewed our control system for flaws and defects that in course of time have led to a disregard for existing regulations. We found that owing to the present turnover in nursing personnel many rules that had been laid down as a help to the conservation of linens had been ignored or forgotten by the older employes. Newcomers were not, or could not be, in-

Master Instruments By Master Craftsmen

This illustration is the SECOND of a series of announcements introducing Master Line of forceps and surgical scissors reproduced in actual size.



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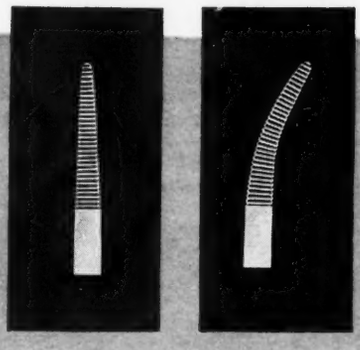

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IRVINGTON, NEW JERSEY

structed properly because of the pressure of work, with the result that linens were damaged or lost beyond normal expectations.

To overcome these difficulties it was decided to review and publish regulations concerning linen usage on floors and dormitories in the form of an appendage to the nurses' manual. At the same time, copies of this presentation were furnished to the teaching staff of our training school for practical nurses, which is an affiliation of the Ballard School.

This material was correlated to the instruction program and helped to familiarize students with the procedure that we follow.

In addition, the outline has helped to draw attention to some of the abuses to which linens are commonly subjected and has also aided materially in our effort to conserve our supplies.

We hope that this approach to the problem of linen control in war time may prove to be of help to other hospitals, which so far have been loath to reduce their linen service and may wish to adopt a similar program wherever it is suitable to their own conditions.—JACK G. CHARLE, *Beth-El Hospital, Brooklyn, N. Y.*

Job Instructor Training

A group of approximately 60 hospital housekeepers, nearly all of them desperate for help, watched with eager interest a demonstration of job instructor training at the Thursday afternoon housekeeping section of the Tri-State Hospital Assembly, May 5 to 7.

The two hour discussion, conducted by Ted Case under the auspices of the Chicago board of education, was the first of a series of six lectures on the War Manpower Commission's Training Within Industry program. The remaining five lectures were given within three weeks following the Tri-State meeting and were attended by approximately 25 housekeepers.

In his initial lecture Mr. Case pointed out to his audience the benefits that would accrue to the hospital, the housekeeper, the patient and the community if efficiency among housekeeping personnel were increased by 25 per cent.

Using the "underwriter's knot" as a sample problem, the speaker demonstrated with three "victims" the wrong and right ways of teaching a new employe his job. The proof of the value of the proper method of instruction, *i.e.* both explaining and showing, one step at a time, was demonstrated by the speed and efficiency with which the pupil grasped the principle of the problem and successfully mastered the technic of tying an underwriter's knot.

Do you have your copy of the "Proceedings" of the first Chicago Institute for Hospital Housekeepers? A few copies of the book, which contains valuable reference material for housekeepers, are still available from Mrs. Alta M. La Belle, housekeeping director, Michael Reese Hospital, Chicago. The price is $2.

District Council Meeting

Delegates to the N.E.H.A. Eastern District Council and Executive Council meeting gathered in Hartford, Conn., May 21 and 22. Highlights of the session included a discussion on safety engineering; a job instructor training program given by a representative of the War Manpower Commission, and a description by an Army officer of the problems involved in turning hotels into hospitals. An "Information Please" panel on housekeeping problems was held on Friday afternoon. Experts on the panel included Mrs. Grace Brigham, Hotel Biltmore, Providence, R. I., Mrs. Alta M. La Belle, Michael Reese Hospital, Chicago, and Mrs. Helen Kidd Thompson, Brown University, Providence, R. I.

FOOD SERVICE

WASTE NOT—WANT NOT

Applies to the kitchen, too

MAXWELL S. FRANK, M.D.

ASSISTANT DIRECTOR, MOUNT SINAI HOSPITAL, NEW YORK CITY

AS THE result of national food rationing, extensive adjustments are being made in food service throughout Mount Sinai Hospital, New York City. Menu changes are designed to meet the restrictions imposed upon institutions without causing undue hardships to the patients. Inasmuch as the food rationing policies are in a state of flux at this writing, only current practices, mostly the result of voluntary economies, are enumerated. As amendments to General Ration Order No. 5 appear, the hospital will adjust its food service accordingly.

Eggs: Eggs served at breakfast to patients are prepared to order in the floor pantries and not in the kitchen.

SEE PAGE 55 OF THIS ISSUE FOR THE BEGINNING OF DOCTOR FRANK'S STUDY ON CONSERVATION

These amusing but significant posters are designed to catch the eye of even the most thoughtless employe and persuade him to be more careful.

All unused and unbroken cooked eggs are returned to the kitchens. Frozen eggs are used in the bakery. Medium sized eggs are served in all the employe dining rooms and to ward and semiprivate patients. Large mixed colored eggs are served in private pavilions. The egg market is carefully followed in the trade journals and adjustments are made whenever changes in market quotations favor the hospital.

Bread and Butter: Instead of placing bread and butter on every tray, they are served separately and only upon request. Butter has practically been eliminated from baked desserts, shortening and margarine being

used as substitutes. In dining rooms where little bread is used, it is no longer placed on the tables but is served upon request.

Milk: Dried milk and evaporated milk are substituted for fresh milk wherever possible for cooking purposes.

Sugar: Sugar consumption has been reduced almost 50 per cent as a result of rationing and voluntary economies. Menus have been adjusted to use less sugar; for example, cake frostings, sauces, pie meringues and recipes using much sugar have been eliminated. Where possible, substitutes for sugar are being used for cooking purposes. In all cafeterias, sugar is served only at the beverage counter. Sugar is delivered once daily to semiprivate and ward pantries and the charge nurse is held responsible for the twenty-four hour supply. In the private pavilion, the word "sugar" has been added to the menus, thus allowing the patient to indicate by checking if sugar is desired.

Tea: Consumption of tea has been considerably reduced below the amount used last year. Tea bags are served only upon order in the private and semiprivate pavilions. The quantity of loose tea sent to the wards has been reduced. Iced tea was eliminated from the dining rooms last summer.

Cocoa and Chocolate: These are used only when necessary to meet an individual patient's requirements.

Coffee: Consumption of coffee was voluntarily reduced before rationing. Since rationing, an additional reduction has been effected. At first coffee was discontinued with the noonday meal in the staff and employe dining rooms three days a week; the service in the other dining rooms remained the same, that is, it was served only at breakfast and at the evening meal. With the more stringent reduction forced by rationing, coffee is now served throughout the hospital only at breakfast. By using a finer grind of coffee, it was possible to reduce the proportion from 2½ pounds per 5 gallons of water, to 2¼ pounds per 5 gallons of water. It is felt that further dilutions may give more liquid, but not more coffee. The quantity of coffee sent to pantries has been reduced. In the private pavilion, coffee is distributed from the kitchen and only as ordered by the patient.

Meat: More meatless meals are being served. Cold cuts as alternate choices with fish meals were discontinued. The average per capita consumption of meat during 1941 was 3.5 pounds per week. By October 1942 it had been reduced to 2.5 pounds and early in 1943 the average weekly per capita consumption had dropped below 2 pounds.

Extra Nourishments: These (eggnogs, cocoa, fruit juice) are served only when ordered by the attending physicians.

Menus: Menus have been posted in all dining rooms so that the personnel will not be served food that it does not eat. They are prepared one week in advance but are subject to change in accordance with daily market prices. They are planned to include less expensive dishes, palatably prepared, with ever-increasing vigilance against oversized portions, waste and rising food prices. This requires careful and constant study of market values and ingenuity in meeting food problems without sacrificing food standards. The supervisors instruct the nurses to serve smaller portions and to give second helpings when requested.

An ironic note has been added by governmental rationing. Hospitals that have been conducted economically with voluntarily instituted conservation programs are penalized by the official rationing orders. These institutions had already pared their consumption of critical materials close to the bone. Rationing quotas based on a small percentage of the supplies that had already been cut to the irreducible minimum may be too meager even for the most economy-minded. However, we feel it our duty to offer full cooperation to the government, which we are sure will not allow the sick in the nation's voluntary hospitals to be deprived of the food, drugs or other supplies needed for their recovery.

Signs of the Times in Food Service

One of the signs of the times at the Hospital for Joint Diseases, New York City, is the discontinuance of selective menus for private patients for the duration, or at least until the help situation is more favorable. Mrs. Mary K. Bloetjes, dietitian, discovered that the compilation of the various items was too time-consuming. Regular and soft menus are offered and, in addition, the dietitian on the floor visits each patient daily to ascertain his preferences, also what special dishes he might like, provided they are procurable. Few complaints are reported thus far.

• •

Another change at the Hospital for Joint Diseases is noted in the staff dining room. Maid service has been eliminated and the doctors now wait upon themselves, cafeteria style. The help thus relieved has been transferred to more important tasks in the kitchen.

• •

Replacing men with women in the hospital kitchen has its difficulties, Mrs. Bloetjes finds. After a short time their femininity comes to the fore and they become too fragile to do the work. They begin calling upon the men for assistance with the result that soon the men are doing three fourths of their work. It would be amusing were the situation not so critical, Mrs. Bloetjes explains, adding, "It isn't that I don't make it clear at the start that the work is hard. I never believe in overselling a job and would rather have them know the worst before they start in."

• •

As a war-time measure to relieve the help situation in the dishwashing department, Margaret Cowden, director of dietetics, Michael Reese Hospital, Chicago, reports that she is experimenting with the use of paper dishes in one men's ward and is also proposing to give them a trial in the children's buildings and in one of the women's wards. The type she is using has a hard finish in which there is little absorption. These have not been in use long enough to draw definite conclusions. Thus far, the chief criticism has been that coffee does not taste the same. Miss Cowden believes that it may be the odor of wet paper that is objectionable rather than the taste. Most of the men seem to feel that satisfying meals are what count rather than whether the food is served on china or paper. It is possible that the women will be more critical.

Findings on PEANUT FLOUR

reveal the value of this hitherto little known food

PEANUT flour which first attracted the attention of nutritionists during the first World War has, through improved methods and treatment, gained new importance until today the product is ideally suited in color, flavor and nutritional characteristics to war-time menus. Many of the difficulties encountered in the earlier stages of its development resulted from lack of proper processing equipment and food plant engineering technic.

According to a survey of the situation by Donald S. Payne, senior technologist, Agricultural Marketing Administration, U. S. Department of Agriculture, as reported in the 1942 Yearbook of the National Peanut Council, Inc., "Experience to date indicates that peanut flour can be produced by the expeller or hydraulic press or by solvent extraction methods. Such methods have been used in the past in the processing of peanuts for the production of oil and the by-product press cake or flakes. But such processes do not require the exclusion from the press cake of sticks, stems, hulls, insect remains, decomposed kernels and various other foreign materials that are commonly present in farmers' stock peanuts.

Oil Can Easily Be Refined

"Such materials do not normally adversely affect either the quality of the peanut oil, as it is amenable to highly efficient methods of refining, or the use of the press cake in animal feeding. These foreign materials, however, make the press cake or flakes wholly unfit for use as human food.

"The manufacture of such press cakes or flakes as a food product, therefore, necessitates a major departure from usual oil mill practice, in that the raw material must be of the best quality and thoroughly cleaned before crushing. In the processing of flour from peanuts the oil no longer can be considered the primary product and the press cake the by-product. Rather, the press cake must assume the position of the product controlling the operation of the various processes.

"In two of the usual methods of crushing peanuts, the hydraulic and expeller press, a more or less severe heat treatment is given the decorticated nuts in order to facilitate the pressing of the oil. This heat treatment induces many changes in the nonoleaginous portion of the peanut. In terms of peanut flour production, certain of these changes are desirable and others highly undesirable.

"A certain amount of cooking is necessary to facilitate the reduction of the oil content, to improve the flavor and to reduce the moisture content. A minimum of cooking is desirable in that even slight cooking adversely affects color, induces changes in the proteins and causes destruction of significant quantities of thiamin. It has been possible to reach a compromise between overcooking, which causes a loss in nutritional value, and undercooking, which limits the removal of the oil and makes more difficult the further processing of the cake into flour.

"One of the factors limiting the early production of peanut flour was the difficulty in sizing the ground cake. The only method described was that of bolting, the same method by which wheat flour is produced. This proved highly unsuccessful inasmuch as the peanut flour blinded the bolting cloth, necessitating frequent cleaning and excessive cloth area. The sizing operation has been successfully and economically accomplished with mechanical air separators which float the flour fraction from the coarser ground portion by means of an air stream.

"Many problems not mentioned in the literature were encountered and had to be solved before the production of peanut flour could be called a success. All such problems have been successfully worked out and production of an excellent grade of peanut flour is now past the laboratory and pilot-plant stage."

Specifications for Peanut Flour

Tentative specifications of the low-fat peanut food flour now in use are as follows: Hulls and skins removed; free from particles of hair, insect fragments or other foreign material; light in color; bland and free from any bitter or raw taste; less than 3 per cent fiber; not less than 5 per cent or more than 9 per cent fat; not less than 55 per cent protein with protein content specified; not more than 10 per cent moisture, and not less than 95 per cent through 120 mesh U. S. standard screen.

The proximate composition of such peanut flour made from the white Spanish type of peanuts is as follows:

		Range
Protein	60%	55-62%
Fat	7%	5- 9%
Fiber	2.5%	2- 3%
Water	6%	2-10%
Thiamin	4.0 I.U./g.	
Riboflavin	5.0 Mcg.	
Niacin	350.0 Mcg.	

Peanut flour may be used for blending with cereal flour in baking to increase the protein content; as an extender and binder in meat loaves, sausage and other meat products to maintain or increase the protein content; as a base material in dry soup concentrate, and for blending with cereals, such as wheat, corn meal, hominy grits, rolled oats, farina and various prepared dry cereals.

Recently, dry soup concentrates containing peanut flour have been receiving wide recognition and consideration is being given to the use of peanut products in cereals for undernourished groups.

FOOD CONVEYORS

"CONQUEROR" WAR MODELS FOR HOSPITAL USE

Plate No. 4107

• Built of less-critical materials, these electrically-heated food conveyors are now available to hospitals furnishing suitable priorities. Conforming strictly to "CONQUEROR" standards of design and construction, they will give long and satisfactory service. Body is made of high-grade galvanized steel, finished in baked enamel. Top deck, end shelves and food containers are of porcelain-enameled steel. Wheels are of a new, tough plastic (though rubber-tired wheels can be furnished for hospital use). The continuous bumper around base is of hard, water-proof and flame-proof felt. All containers are suspended in one large, common well, heated by space heaters connected to a three-heat switch. Conveyor illustrated above will feed 65 to 80 patients. Other models of various capacities are available to suit specific requirements.

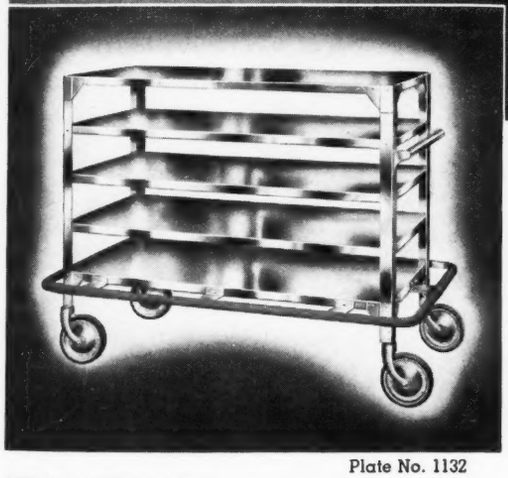

Plate No. 1132

TRAY TRUCKS Sturdily built of heavy galvanized steel. Swivel casters. Continuous bumper of hard, water-proof and flame-proof felt. Trucks are available in several sizes to suit specific requirements.

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EST. 1889 **CONQUEROR** LEADS THE WAY

Equipment for Hospitals in a New World

Our Diet Under Rationing

IF THE hospital diet is now meeting the nutrition standards set up by the National Research Council, the minor changes caused by rationing will not endanger the nutritive values of the diet, Dr. Kate Daum, director of nutrition of the University of Iowa, recently told the Iowa Hospital Association.

The allowance of vitamins was liberal under the council program and some reductions can be made without hazard. Most hospitals find that they have to get along now on about 75 per cent of the meat formerly used. Milk and eggs, if they can be obtained, can be substituted for meat in maintaining the protein content. If milk is difficult to obtain, soybeans and peanuts can be used.

Soybeans constitute a useful form of protein, an even more efficient source than navy beans or peas. Just now soybeans are scarce but Doctor Daum predicts a more generous supply next winter. They may well be used as a meat extender or a meat substitute, slightly larger quantities being used than of meat.

The restriction of butter is not unduly serious, in Doctor Daum's opinion, inasmuch as it is not the sole source of vitamin A. We also obtain vitamin A from whole milk, green vegetables, liver and legumes. There is no danger in the per capita allowance of ¼ pound per week if the diet has the necessary vegetables. Margarine can be substituted because, year in and year out, it is a slightly more dependable source of vitamin A than is butter. Most hospitals now use butter only for table or tray service and only one pat per person per meal. Margarine or other substitutes are used for cooking.

The greatest rationing hardship to hospitals is in the restriction of canned fruits and vegetables. With labor so hard to obtain and hold, it is now more difficult to substitute fresh fruits and vegetables when they are in season. There are no substitutes for vegetables in a proper diet. Doctor Daum suggests, however, that hospitals experiment far more than they have with the use of raw vegetables to save preparation time and vitamins.

Is there a danger that the calories in the diet will be excessive because of increase in cereal consumption? There is some possibility of this, Doctor Daum states, but it is minimized by the reduction in the use of sugar, fats and oils. Furthermore, many cereals nowadays are fortified with added vitamins so that we are actually increasing the value of the diet.

Patients usually cooperate well with the dietitian in effecting the necessary menu changes caused by rationing, as they are well acquainted with the rationing problems at home.

It is not always smooth going with student nurses and young doctors, however. Doctor Daum advocates an educational program to inform them about the point values of various foods so that they will understand, for example, why catsup with its excessively high point value no longer appears on the table. She has substituted horseradish and it has been well accepted.

During World War I, meatless days were not successful because meat was unrationed and people merely ate more on the other days. Meatless days probably would be more successful today, but Doctor Daum prefers to omit meat from lunches and suppers rather than from a whole day's menus. People usually judge the amount of meat by the size of the portion so meat extenders may be used if the flavor is not diluted too much.

Dietitians will have to be adept at devising short cuts in the kitchen to meet the labor shortage. In addition to serving more vegetables raw, Doctor Daum suggests serving both boiled and baked potatoes in their jackets. She also advises planning menus that can be served all on one plate to save handling many dishes and much dishwashing.

Paper plates, paper sauce dishes and even paper cups for hot coffee offer another possible saving; they seem to be acceptable under war conditions to the patients and employes of the University of Iowa Hospitals.

More and more will hospitals simplify special diets and make them similar to the general diets. At the University of Iowa Hospitals diabetic patients are put on a general diet very near to that which the other members of the patient's family will use. This is a great help to the patients and enables them to avoid asking for supplementary points.

Bits About Butter

HERE is how the butter situation is being met by dietitians in one metropolitan center.

Dietitian A reports that private and semiprivate patients are the only ones being served butter and they are continuing to get it three times daily. Ward patients and personnel are getting margarine and there have been no complaints to date. Before taking definite action, a check-up was made and it was discovered that these people were using margarine in their homes; consequently, there seemed to be no reason why they should not use it in the hospital.

Dietitian B is serving butter on trays once a day only, for breakfast. An investigation among patients revealed that they would prefer to have butter on their toast in the morning and do without it at other meals. A small portion of jelly or peanut butter is substituted for butter on dinner and supper trays.

Dietitian C, instead of discriminating between private patients and others, has cut down the allotment of everyone from a full square to a half square three times daily.

Dietitian D declares that when she has butter all patients get their share; when she hasn't any they do without and with few exceptions they are philosophical about the situation. A simple explanation, she has found, has gone a long way in eliminating any misunderstandings.

From these experiences it is evident that each dietitian must solve the problem as seems best in her particular institution.

July Dinner Menus for the Small Hospital

Evelyn Nutting

Dietitian, Highland Park Hospital Highland Park, Ill.

Day	Soup	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Consommé	Lamb Chops	Baked Potatoes	Fresh Peas	Fruit Salad	Gingerbread, Cream Cheese and Lemon Sauce
2.	Cream of Corn Soup	Halibut	Parsley Potatoes	Stewed Tomatoes	Lettuce, French Dressing	Snow Pudding, Custard Sauce
3.	Vegetable Soup	Pot Roast	Buttered Noodles		Endive, Dressing	Blueberry Kuchen
4.	Cream of Pea Soup	Liver and Bacon	Baked Potatoes	Buttered Spinach	Tomato and Lettuce Salad	Peaches and Cream
5.	Alphabet Soup	Cubed Steaks	Pan Browned Potatoes	Buttered Cauliflower	Endive and Carrot Salad	Chocolate Sponge
6.	Broth With Rice	Roast Chicken	Mashed Potatoes	Fresh Asparagus	Celery and Olives	Vanilla Ice Cream
7.	Bouillon	Lamb Stew	Boiled Potatoes	Peas and Carrots	Pear and Lime Gelatin Salad	Coffee Torte
8.	Cream of Celery Soup	Roast Leg of Veal	Mashed Potatoes	Buttered Green Beans	Spiced Peaches	Orange Sherbet
9.	Cream of Mushroom	Perch	Potatoes au Gratin	Buttered Fresh Peas	Tomato Salad	Apricot Icebox Cake
10.	Chicken Noodle Soup	Beef Loaf	Baked Potatoes	Zucchini, Tomato Sauce	Lettuce, French Dressing	Rice Pudding
11.	Tomato Broth	Chicken Pie With Mixed Vegetables and Potatoes			Lettuce, Thousand Island Dressing	Bing Cherry Gelatin, Cream
12.	Bouillon	Roast Beef	Pan Browned Potatoes	Buttered Fresh Green Beans	Spring Salad	Grapenut Ice Cream
13.	Alphabet Soup	Codfish Patties, Cream Gravy	Baked Potatoes	Buttered Carrots	Pear and Mint Gelatin Salad	Caramel Tapioca
14.	Tomato Broth	Baked Ham	Candied Sweet Potatoes	Spinach Soufflé	Lettuce, Thousand Island Dressing	Fruit Cup, Icebox Cookies

July Dinner Menus for the Small Hospital

Day	Soup	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
15.	Scotch Broth	Swiss Steak	Buttered Rice	Buttered Wax Beans	Fruit Salad	Chocolate Ice Cream
16.	Cream of Corn Soup	Baked Trout	Buttered Parslied Potatoes	Julienne Beets	Endive and Radish Salad	Baked Custard
17.	Vegetable Soup	Liver and Bacon	Baked Potatoes	Buttered Green Beans	Raw Spinach Salad	Strawberry Shortcake
18.	Noodle Soup	Hamburger Patties	Escalloped Potatoes	Buttered Carrots and Celery	Lettuce, Russian Dressing	Apple Crisp
19.	Bouillon	Broiled Lamb Chops	Creamed New Potatoes	Fresh Asparagus	Fresh Fruit Salad	Chocolate Roll, Chocolate Sauce
20.	Rice and Chicken Giblet Soup	Roast Chicken	Mashed Tomatoes	Baked Eggplant	Grapefruit and Avocado Salad	Ice Cream, Raspberry Sauce
21.	Julienne Soup	Roast Sirloin Butts	Mashed Potatoes	Creamed Peas	Tomato and Watercress Salad	Grape Sherbet
22.	Alphabet Soup	Ham Loaf	Baked Potatoes	Cauliflower	Combination Salad	Watermelon
23.	Cream of Pea Soup	Pike	Escalloped Potatoes	Glazed Carrots	Perfection Salad	Baked Lemon Pudding
24.	Consommé	Veal Cutlets	Buttered Parslied Potatoes	Wax Beans	Head Lettuce, French Dressing	Raspberry Bavarian
25.	Chicken Rice Soup	Cubed Steaks	Pan Browned Potatoes	Buttered Summer Squash	Celery Hearts and Olives	Prune Whip
26.	Bouillon	Roast Leg of Lamb	Mashed Potatoes	Buttered Peas	Lettuce, Dressing	Strawberry Ice Cream
27.	Scotch Broth	Baked Eggs in Potato Puffs		Diced Beets	Lettuce, Roquefort Dressing	Banana Cake
28.	Noodle Soup	Baked Ham	Baked Potatoes	Green Beans	Spiced Crabapples	Four Fruit Sherbet
29.	Split Pea Soup	Liver and Bacon	Escalloped Potatoes	Stewed Tomatoes	Lettuce, Pickle Rings	Floating Island
30.	Cream of Asparagus Soup	Baked Salmon	Buttered Parsley Potatoes	Buttered Spinach	Tomato Salad	Apricot Upside-Down Cake
31.	Chicken Broth	Swiss Steak	Mashed Potatoes	Carrots and Peas	Watercress Salad	Red Cherry Cobbler

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago.

What every hospital Dietitian should know about RY-KRISP!

Ry-Krisp is a natural whole grain bread . . . probably the only out-and-out whole grain bread available nationally. Baked into crisp ready-to-eat slices.

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New Low-Calorie Diet Book gives 1200-calorie diet for women, 1800 for men. Includes menus, recipes.

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Impetigo Meets Its Match In New Sulfathiazole Treatment

T. N. HARRIS, M.D.
DEPARTMENT OF PEDIATRICS
UNIVERSITY OF PENNSYLVANIA

OF ALL of the disruptions of hospital routine, one of the commonest and most disturbing is an outbreak of impetigo contagiosa.

To the medical and nursing staff it involves additional work in repeated examinations and treatment and in special precautions. To the hospital administration it involves prolonged bed occupancy, the embarrassment of a hospital-contracted infection and, often, the shifting of patients in an entire ward. To the laundry it means an additional load of linen, usually grease-spotted or deeply stained when one of the two classical methods of treatment is used.

Mercury, Gentian Violet Used

These two methods of treatment, ammoniated mercury ointment and gentian violet, respectively, were practically the only methods used until quite recently. Unfortunately, these treatments required at least two or three weeks, in almost all cases, to effect a cure. During this time frequent removal of crusts and reapplication of the medication were necessary. Since, however, the lesion is superficial and the bacteria spread readily over the skin, it was hardly possible to maintain over so long a period of time the precautions necessary to avoid spread of the disease. The usual sequence was, then, that while one crop of lesions was under treatment other lesions would appear on the skin of the same patient and others.

Within the last three years the problem of impetigo has become acute, especially in England, and the dissatisfaction with these methods of treatment has been correspondingly great. Almost a dozen different treatments have been suggested by medical writers, most of them apparently only slightly better than the older two methods.

One group of treatments has, however, shown definitely better results, *i.e.* the various treatments with sulfonamides (usually sulfathiazole). These have included oral administration, application of ointments and local application of powder. About 20 sets of data have been reported in the recent medical literature.

The results of various investigators fall into a fairly similar pattern, whether the method is oral, by ointment or by powder. In general, from four to seven or more days are required for healing an impetigo lesion by these methods. Usually, the drug is administered three or four times a day, or oftener, and crusts must be removed and the skin washed once a day. During this treatment further spread and the appearance of new lesions can occur.

Recently, a new method of treatment has been described that should do away with a great deal of the difficulty in controlling impetigo. This new development was made possible by the availability of a new physical form of sulfathiazole. This material, while chemically identical with the tablets or powder, differs in physical form so that it forms a stable suspension in water, that is, it "stays up" like milk of magnesia, which it resembles in appearance. Ordinary sulfathiazole powder, in contrast, will settle and cake when suspended in water.

The new preparation is known as micraform (or microcrystals of) sulfathiazole because the particles of drug are presumably separate microscopic natural crystals.

The sulfathiazole in this preparation seems to achieve better contact with the bacteria of impetigo when applied to the clean base of the lesion than is the case in other forms of the drug. I have treated impetigo by applying to the site of the lesion a bit of this emulsion, thickened to the consistency of mud, on a gauze dressing. The skin was prepared only by soap and water cleansing after removal of the softened crust. A single such application has been found to cure the lesion in twelve hours or less and to prevent spread of the disease from that lesion as a source.

This means that when an outbreak of impetigo is discovered in a ward, the lesions can be brought completely under control in as short a time as it takes to examine thoroughly the patients involved and their neighbors, remove crusts and wash the lesion and surrounding skin well with soap and water and apply the dressings. On the following morning only a little fine powder is found between a clean pink base of each lesion and its dressing, which is not adherent. No further treatment is necessary for these areas.

Few Lesions Overlooked

A few minute or incipient lesions may escape treatment on the first day because of being either overlooked or in a stage of incubation, but these would be full blown and recognizable by the second day and, upon being treated once like the other lesions, should heal similarly and not become starting points for fresh spread. The success of the method depends, of course, on the thoroughness of both the examination for lesions and the soap-and-water cleansing of affected and suspected skin areas.

It is important to note that there are ways of incubation or spread of the bacteria other than directly from lesion to lesion. For example, small breaks in technic of the medical or nursing staff or a nose or throat infection in a nurse may enable one of these to harbor the bacteria for a while. From such a point of incubation the same strain of bacteria may, on contact with a patient, start a fresh outbreak of what is, technically, the same epidemic, even though the ward may have been clean of lesions for days.

The treatment here described is a method of curing lesions and preventing further direct spread from them; to be completely successful in checking epidemics, we must assume careful technic on the part of the staff to prevent indirect spread or a fresh flaring-up of the epidemic. Occasionally, it may even be necessary to conduct bacteriologic nose and throat examinations of the staff.

It need hardly be pointed out, especially to hospital administrators, that no prediction or guarantee of cure can ever be made in each individual case. It is quite possible that bacteriological or mechanical factors will make an occasional lesion or group of lesions more resistant to treatment than the norm. Such lesions may require a repetition of the treatment. The value to hospital administration of this contribution from medical research is that it simplifies the treatment usually to a single application per lesion of a white water-suspension of powder and, more important, that it can be expected, first, to cut the duration of an epidemic of impetigo to one or two days and, second, to stop the spread of the disease as of the time it is first discovered.

For Filtering Parenteral Solutions

GEORGE T. GRIGGS

CHIEF PHARMACIST
BATTLE CREEK SANITARIUM
BATTLE CREEK, MICH.

IN THE preparation of any parenteral solution proper filtration has a definite place in the avoidance of complications that might arise from administration. For small volumes of solutions the Seitz filter with either positive or negative pressure has proved satisfactory.

The Jena and heatproof fritted glass filters are fine for such filtrations as Collyria but their porosity is greater than is suitable for parenteral solutions. The diameter of the pores in these filters is somewhat larger than the bacteria which they are often used to eliminate. Thus, it may be seen that a filter of this type will give one a feeling of false security.

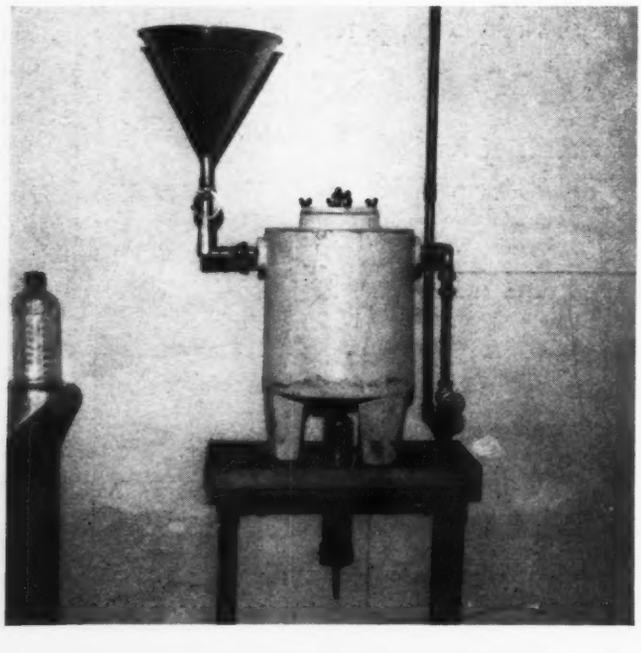
The Berkefeld filter with negative pressure does a thorough job of removing bacteria from solutions but often there is a boiling of the solvent in the receiving chamber and with quantities exceeding 1 or 2 liters it is tedious.

While there are several pressure chambers commercially available, these chambers are fairly expensive, as a matter of fact so expensive that many hospital administrators hesitate to invest in them when other types of filters will produce reasonable clarification of the solution.

At Battle Creek Sanitarium, Battle Creek, Mich., we had cast a round chamber with a volume of approximately 5 gallons. The only other specifications we made to the foundry were that it should withstand a pressure of at least 125 pounds per square inch and that it have an opening at the top of not less than 5 or more than 6 inches. After the casting was made it was milled and drilled in the proper places, then enameled and baked. The standard Berkefeld washing chamber is used to hold the filter candle and all other parts except the filling funnel are standard dairy fittings made of stainless steel.

Compressed air from the general air supply line is used as the motive power.

The filter is suitable for volumes of solutions of from 2 to 15 liters and our over-all cost has been less than $75.



A special pressure filter used in the pharmacy of Battle Creek Sanitarium, Battle Creek, Mich. The standard Berkefeld washing chamber is used to hold the filter candle. All other parts except the filling funnel are standard steel dairy fittings.

To reduce the chance of by-effects

Pantopon 'Roche' contains *all* the active alkaloids of opium — not merely morphine. These alkaloids are present in the same proportion as nature provides them in the poppy, but free from gums, resins, and inert materials. In such combination the therapeutic principles seem to have a natural balance that provides smoother opiate action, reducing the chance of by-effects so commonly encountered when morphine alone is used. That is why Pantopon has been adopted as a routine opiate by so many leading physicians in the various fields of medicine and surgery. When opiate medication is indicated, try ⅓ gr. of Pantopon 'Roche' instead of the usual ¼ gr. of morphine. HOFFMANN-LA ROCHE, INC., ROCHE PARK, NUTLEY, NEW JERSEY.

USE **PANTOPON 'ROCHE'**
IN PLACE OF MORPHINE

You DO Need a PHARMACIST

PETER M. CLAIR

PHARMACIST
JACKSON PARK HOSPITAL
CHICAGO

IT IS obvious that if a hospital superintendent who does not now employ a pharmacist were shown to his complete satisfaction that the installation of a pharmacy would enhance the revenue and prove an asset rather than a liability to the institution, he would naturally deem it unwise to be without one.

To gain a true perspective on this question two factors must be considered: first, the size of the hospital that can maintain a pharmacist profitably; second, the number of such hospitals at present operating without pharmacists.

In considering the size that a hospital must attain before it can profitably employ a pharmacist, the answer, of course, cannot be really definite. However, if one is to use as a criterion some of the smaller institutions that are now employing pharmacists and finding it a sound investment, it may safely be stated that any hospital with a capacity of 75 beds or more that does not have a pharmacist is depriving itself of an excellent source of income.

In considering the second factor, *i.e.* the number of such hospitals that do not employ pharmacists, the figures are amazing. Incredible as it may seem, in Chicago alone, approximately 20 per cent of the hospitals having 75 or more beds do not have the services of a pharmacist.

Now, wherein and to what extent is the pharmacist an asset to the hospital? How does the hospital that employs one have the advantage over the one that does not have a pharmacist?

To answer these questions, several definite and distinct reasons will be set forth; they will be given, more or less, in the order of their importance.

1. **Financial Return.** To prove the earning merits of a hospital pharmacy, two hospitals having about 100 beds each and employing pharmacists will be used as examples. The pharmacy department of each fills on an average of from 15 to 20 new prescriptions and from five to 10 refills daily. Assuming that the average prescription costs the patient $1, the revenue from this department amounts to between $600 and $900 monthly.

If the profit is calculated on a basis of only 50 per cent of the sale, and it is common knowledge that some prescriptions yield a better profit than that, the gross profit realized by each of these two hospitals amounts to approximately between $300 and $450 per month from the prescriptions alone. Since many hospital pharmacies carry sundry items akin to pharmacy, it should not be difficult to get an idea of how profitable a hospital pharmacy can be even in a small institution.

2. **Dispensing Medications.** Inasmuch as only a pharmacist is qualified to perform this duty, the hazard of making mistakes in medications is ever present where there is no pharmacist, and the administrator is thus burdened with an additional unnecessary responsibility.

3. **Purchasing.** While this may sound like undue exaltation, it is nevertheless true that the pharmacist is the person to do the purchasing most competently. For he alone, by virtue of his training, is qualified to purchase drugs and pharmaceuticals intelligently and economically. In this connection, he is also in a much better position to price the medications to the patients correctly.

4. **Control of Charges.** When there is no pharmacist, regardless of how good a system the hospital may use in charging for medications, many losses are sustained by the institution. Because the duty of charging the medications to the patients is necessarily delegated to the supervisor of each floor, it automatically becomes a decentralized system. It is not only conceivable but highly probable that medications are given to patients without a charge being recorded when the supervisor is unusually busy. The main office fails to get a record of the charge and naturally omits it from the patient's bill.

The loss sustained by the hospital in this manner is an unknown quantity, to be sure, but it is there nevertheless. On the other hand, the pharmacist charged with the responsibility of the drug inventory is less likely to permit the dispensing of medications to patients without entering a charge.

5. **Petty Thievery.** The pilfering of drugs and medications that goes on in many hospitals where there is no pharmacist is extremely costly. While this practice may not be perpetrated with any malicious intent, the hospital sustains a loss therefrom nevertheless. However, when a pharmacist is employed, one of his duties is to issue drugs and medications for both the utility rooms of the floors and the floor drug cabinets. He thereby acquires a thorough knowledge of the type of medications and the quantities used in the various departments.

When any undue amount is requisitioned or when repeated demands for costly medications are made, he is quick to sense the irregularity. An immediate check up by the pharmacist will disclose whether the demands are warranted. Thus, the loss to the institution of medication material through pilferage is curtailed. Here, again, the service of the pharmacist is clearly defined.

6. **Service to Staff.** The greatest service that the qualified pharmacist can offer to the members of the medical staff is his knowledge of pharmaceuticals. The physician may call upon him to discuss various therapeutic agents or he may seek the opinion of the pharmacist on the efficacy of some new preparation which the doctor intends using on a patient. While this is only a service to the physician, it is recognized as an additional hospital facility by the staff members to which they often resort.

Abstract from a paper presented to the pharmacy section, Tri-State Hospital Assembly, May 1942.

Antiseptic and Germicide with a New Chemical Structure

ZEPHIRAN CHLORIDE is a mixture of high molecular alkyl-dimethyl-benzyl-ammonium chlorides, and represents a new concept of bacterial destruction on the basis of a cationic detergent.

Welch and Brewer* state that the protective action of the blood plays an important role in infection, and the indiscriminate application of antiseptics which destroy this function at dilutions which cannot destroy bacteria is a harmful practice.

Though a very potent germicide and according to their studies capable of destroying Staphylococcus aureus in a concentration of 1:6,250 in 10% serum, they found ZEPHIRAN CHLORIDE non-injurious to the delicate phagocytic mechanism of the white blood cell in concentrations up to 1:3,000. Expressed in terms of the toxicity index, ZEPHIRAN CHLORIDE was rated as 0.48 whereas alcohol was shown to have a toxicity index as high as 7.5.

DISTINCTIVE ADVANTAGES OF

Zephiran *CHLORIDE*

- DETERGENT PROPERTIES
- A WETTING AGENT
- HIGH TISSUE TOLERANCE
- PENETRATION ABILITY
- RAPID ACTION
- EMOLLIENT EFFECT
- WIDE APPLICATION
- ECONOMY

Zephiran *CHLORIDE* . . . Germicide for Surgery, Obstetrics and Gynecology, Urology, Dermatology, Eye, Ear, Nose and Throat, Sterile Storage of Instruments

*Welch, H., and Brewer, C. M.,: The Toxicity-Indices of Some Basic Antiseptic Substances, Jl. of Immunology, Jan., 1942.

ALBA PHARMACEUTICAL DIVISION NEW YORK, N. Y. WINDSOR, ONT.
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NOTES AND ABSTRACTS

**Conducted by the Staff of the Pharmacology Department
Wayne University, Detroit**

Pharmacologic Preparation for War

Much space has been devoted by the public press to reports on the variety, effectiveness and rate of production of the various agents of destruction used in modern warfare. Only rarely does one find reference to the equally important "medical armaments," the purpose of which is to preserve health and, thereby, morale and to aid in the repair of the wounded and war sick in order that they may again contribute to the national economy or be returned to active military service.

The development and production of this important class of military agents result largely from the cooperative efforts of the experimental pharmacologist, the research clinician and the manufacturing pharmacist. A brief review of some of the principal hazards of modern mechanized warfare and of the development of suitable new medical agents to aid in caring for these, agents developed largely since the war of 1914-18, might be of interest at this time.

The fighting efficiency of an army is reduced by the loss of manpower resulting from the disabilities listed, in the approximate order of their importance. They are: (1) wounds caused by shrapnel, artillery, hand grenade, mine, bayonet, lance, saber or knife; (2) burns and their sequelae; (3) malaria; (4) venereal infection; (5) war neuroses, and (6) nutritional disorders.

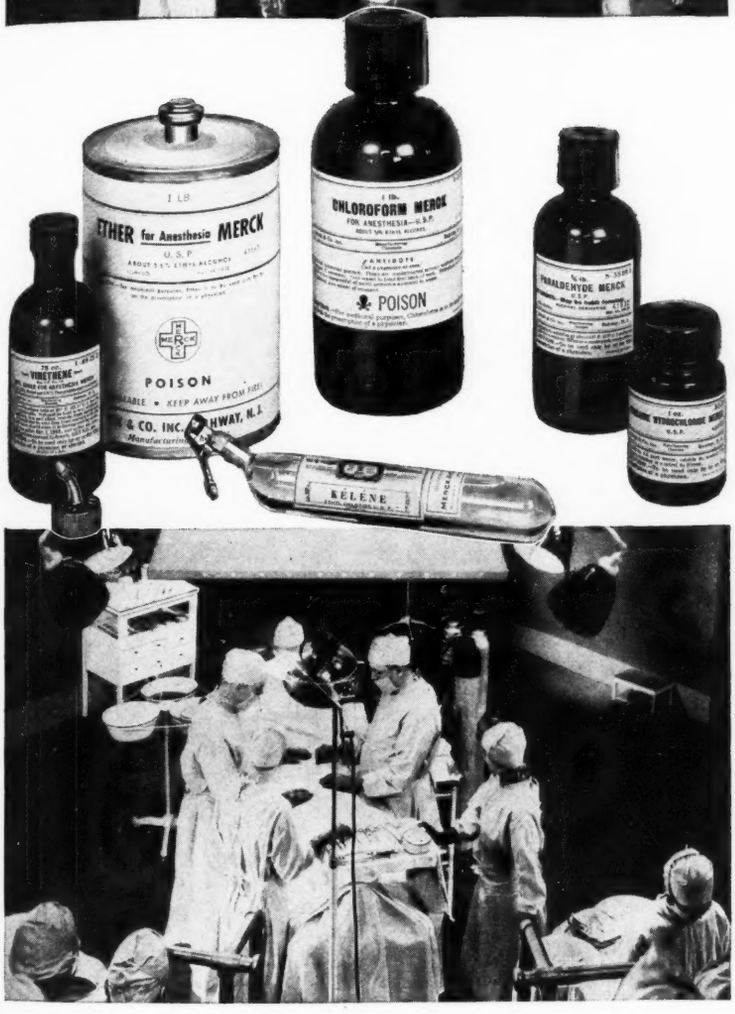
In the discussion that follows, drugs mentioned will be followed in parenthesis with the approximate date of their synthesis or introduction into medical practice insofar as possible.

1. **Wounds.** Hoche (1940) reviewing war injuries concluded that every injury of modern war must be regarded as subject to primary infection. Missiles may come in touch with soil or may drive portions of skin and clothing into the wound carrying with them the usual bacterial infections, staphylococci, tetanus bacilli, colon bacilli or the organisms causing gas gangrene. We have been informed that the Japanese attack on Pearl Harbor, with its resultant large number of bomb injuries, caused no deaths from wound infection. This remarkable fact was due to the presence of an adequate supply of sulfonamide drugs and to their prompt and efficient use. Sulfathiazole (1939), sulfanilamide (1935) and sulfapyridine (1938) are most useful agents in the prevention of bacterial infection and in reducing mortality among those already infected.

The development of new and easily administered analgesics and anesthetics has greatly facilitated the movement of the wounded and their subsequent treatment. Of particular importance in this respect are the various derivatives of barbituric acid that have come into wide use within recent years. With these anesthesia is rapidly induced and emergence is uneventful; they are easily administered; their nonexplosive character permits them to be stored without increasing the fire hazard, and they can be used repeatedly without ill effects. Mention should be made here of the recently introduced synthetic analgesic demerol (1941), which has been suggested as a substitute for morphine.

2. **Burns.** Burn injuries commonly result from gun flash, bomb flash, in-

★ *Second only to the Skill of the Surgeon and Physician*



Aside from the great skill acquired through many years of clinical experience, the surgeon and physician must necessarily depend upon the armamentarium at their command.

Not the least important consideration is the choice of the proper anesthetic, which not only must be pure and dependably stable under all circumstances, but also must exhibit uniform potency at all times.

A background of a century and a quarter in the production of the finest medicinal chemicals has enabled Merck & Co., Inc. to offer the surgeon, anesthetist, and physician, anesthetic agents which merit implicit confidence.

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cendiary bombs and burning gasoline. The increased use of internal combustion engines for transportation and the extensive use of air power for the bombardment of military objectives have resulted in a large number of burn injuries. The use of some rosaniline dyes (1933) as a substitute for tannic acid is receiving considerable attention by clinicians. The triple dye treatment (gentian violet, brilliant green and acriflavine) has been found particularly useful. It is claimed that an injured surface sprayed with this combination is covered with a sterile, thin, supple tan that is free from many of the objectionable features of the older tannic acid treatment. The sulfonamide drugs must again be mentioned here, particularly sulfanilamide, inasmuch as their use prevents or lessens the severity of streptococcal infection.

3. **Malaria.** A major portion of the present conflict is taking place in areas in which malaria is prevalent and infection is almost certain to occur. It is estimated that 85 per cent of all American troops on Bataan were suffering from acute malaria during the last days before capitulation. New Guinea, the Solomon Islands and other tropical and semitropical areas present similar problems and, unfortunately, most of the quinine producing areas are in the possession of the enemy. The small available supply is being supplemented and extended by the use of the synthetic compounds, plasmochin (1926) and atebrine (1930). We may hope these will be adequate to control this disease. In the meantime, vigorous efforts are being made to discover new synthetics that will equal or surpass the therapeutic effectiveness of agents now in use.

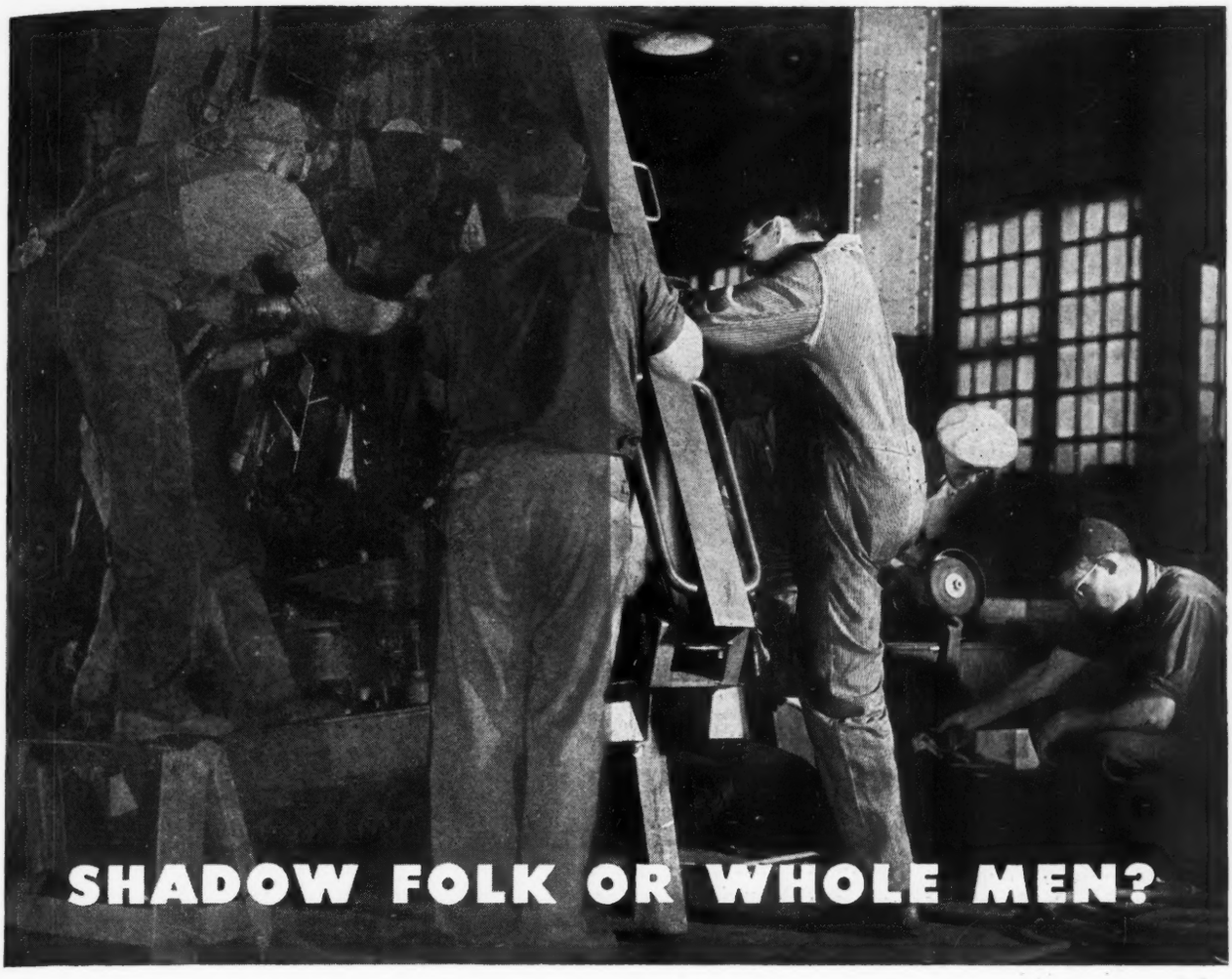
4. **Venereal Disease.** The removal of large numbers of vigorous young men from their accustomed environment and their concentration in training camps and rest camps create difficult social problems. There is the ubiquitous prostitute and with her come the four plagues of fornication: syphilis, gonorrhea, chancroid and lymphogranuloma venereum. Neosilvol (1926) has proved to be an important aid in prophylaxis and when used promptly along with calomel ointment provides adequate protection.

Several new antisyphilitic drugs have been introduced into therapy since World War I. Of particular importance are the new drugs, mapharsen (1932) and sobisminol (1937). In the treatment of gonorrhea, the oral administration of sulfathiazole along with other forms of therapy has been reported to shorten the time of recovery, in some instances to less than two weeks. The treatment of lymphogranuloma venereum has been improved by the use of antimony, particularly organic antimony compounds, such as antimony sodium thioglycollate.

5. **War Neuroses.** This strange illness of warfare is not one in which drugs are extensively employed. However, Hubert, in a recent article published in the *Lancet*, has suggested that the first treatment should be isolation from the environment by the use of hypnotic drugs. The barbiturates have been extensively employed in this connection.

6. **Nutrition.** The feeding of large armies distributed over a major portion of the earth's surface has created unique nutritional problems. Foodstuffs must often be concentrated to the smallest possible volume in order that they may be easily transported and stored in the smallest possible space. Usually the time between purchase and consumption is weeks or months. Although these foods are quite adequate as sources of food energy, the foregoing factors hardly favor a high vitamin content. Special effort must be exercised in their preparation and preservation and vitamin supplements are usually added to correct specific deficiencies.

In addition to the problem of general nutrition, there are those arising from specialized forms of military service. For example, the commando fighter and operators of night fighter planes must receive substantially more vitamin A (1930) than the recommended daily 4000



SHADOW FOLK cloaked from head to foot in mental depression, nervous instability and other vague disorders may be on the increase because of unwise choice of foods by many patients during these troublesome times.

*ABDEC** KAPSEALS* contain standardized high potencies of the essential vitamins in proper balance—and are outstanding in the field of multiple vitamin preparations.

Even persons on extremely unbalanced food intakes are supplied the recognized daily vitamin needs for prevention or correction of definite vitamin deficiency with the administration of *ABDEC* KAPSEALS.

Daily administration: One small Kapseal for patients on diets with a moderate lack of one or more essential vitamin factors. Two or three Kapseals for prevention or correction of definite vitamin deficiency.

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to 5000 units. Inasmuch as activity is limited to the night hours there must be an excess of vitamin D (1924). Similarly, submariners, whose craft can surface only after dark, require larger amounts of these vitamins.

In passing, some mention should be made of the recently synthesized fat soluble vitamin K (1939) necessary for the formation of prothrombin. Although the normal diet provides an adequate amount of this substance, diarrhea common in tropical climates and sprue infection, which interferes with intestinal absorption, may lead to a deficiency. Furthermore, this vitamin is recommended for use pre-operatively and post-operatively or after injuries associated with much loss of blood. Bank blood loses much of its prothrombin on standing. Rapid prothrombin regeneration and a normal bleeding time are favored by an increased intake of vitamin K.

The water soluble vitamins, thiamine (1936), riboflavin (1934), nicotinic acid and ascorbic acid (1933) are now available in pure form and the concentrated vitamins can be easily made available to the armed services. Task forces with limited supplies, shipwrecked sailors and aviators landing in remote areas far from human habitation can maintain an adequate vitamin intake by the use of concentrated synthetic preparations.

The two decades that elapsed between the two world wars have been periods during which many important developments of new and useful therapeutic agents have been made. It is obvious that we must, insofar as possible, maintain our forces at the peak of fighting efficiency, return those with minor injuries to active duty as quickly as possible and return to the "home front" the more seriously injured with a minimum impairment of working efficiency in order that civilian economy may be maintained.

The social problems resulting from an unbalanced sex ratio in the adult population would thereby also be reduced to a minimum. Owing to the efforts of our research staffs and the skill of the manufacturing pharmacists, this task is being successfully carried out.—A. M. LANDS.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Exceptional Contributions

The clinical literature these days is heavy with interesting reading for the hospital administrator. We try to abstract as many of these articles as we can compress into the limited space at our disposal. Recently, a number of exceptional contributions to clinical literature have come to our attention and we would single out the following for special reading by the hospital executive:

"Psychological Aspects of Tuberculosis," Dr. Julian M. Wolfsohn. *Bulletin of National Tuberculosis Association,* March 1943.

A modern interpretation of Sir William Osler's famous epigram: "The care of the tuberculous depends more on what the patient has in his head than on what he has in his chest."

"Standards of Effective Administration of Inhalational Therapy," Committee on Public Health Relations of the New York Academy of Medicine. *Journal of the American Medical Association,* March 6, 1943.

An unusually concise statement of the various methods used in inhalation therapy.

"The Shock Cart," John Scudder. *Surgery, Gynecology and Obstetrics,* March 1943.

A complete description of a mobile unit containing all the equipment necessary for patients in acute emergencies.

"The Treatment of Syphilis With Phenarsine Hydrochloride," W. E. Levy, and "Phenarsine Hydrochloride in the

Treatment of Syphilis," W. E. Guy, B. A. Goldmann and G. P. Gannon. *Archives of Dermatology and Syphilology,* February 1943.

Two reports on a new and potent anti-syphilitic arsenical preparation of low toxicity. These preliminary studies appear to justify the drug's continued use under carefully controlled conditions.

"The Fraudulent Use of Digitalis to Simulate Heart Disease," O. F. Hedley. *Annals of Internal Medicine,* February 1943.

The findings on three patients who succeeded in producing various signs and symptoms of heart disease by the self-administration of digitalis in an attempt to defraud the insurance companies.

"The Known and Unknown in the Problem of Optimum Nutrition," A. J. Carlson. *Gastroenterology,* January 1943.

An analysis of the present unreliable methods of diagnosis of incipient dietary deficiencies; a comparison between the modern American and the minimum adequate diets.

"Continuous Caudal Analgesia in Surgery," Drs. James L. Southworth, Waldo B. Edwards and Robert A. Hingson. *Annals of Surgery,* March 1943.

This simple, accurately controlled method for prolonged caudal block has been found useful in plastic operations about the rectum and perineum; in surgical and orthopedic repair of traumatism of the lower extremities, and in operations below the umbilicus in the aged and debilitated.—S. L. Friedman, M.D.

Gonorrhea and Sulfathiazole

Jefferiss and McElligott have analyzed in the *Lancet* (Jan. 16, 1943) 567 cases of acute gonorrhea that were treated with sulfathiazole. Most of the patients were treated for three days or less, for once it became apparent that good results followed the shorter courses those of four and five days were discontinued. Likewise, the larger total daily dosages were stopped and a dose of six grains per day was adopted as the optimum. No adjuvant treatment such as irrigation was given; no dietetic restrictions were enforced, but a daily fluid intake of at least five pints was insisted upon.

The patients were followed up after discharge, which usually occurred within one week after admission, by their unit medical officers with an occasional observation by an approved medical center.

There were no serious toxic effects, although a few cases of drug rash appeared among the unsuccessful cases when a second course of chemotherapy was attempted.

The "success rate" in this series was 89.5 per cent, which is slightly higher than that reported by the authors when they used sulfapyridine.—Sigmund L. Friedman, M.D.

The Recovery Room

This article is a plea for the extension of the idea of the recovery room. Strong Memorial Hospital in Rochester, N. Y., has for the past year provided a recovery room for surgical patients during the immediate postoperative period. This room, centrally located, has been made large enough to accommodate several patients at once; has been adequately equipped with suction apparatus, shock blocks and fluid standards, in addition to the customary ward equipment, and has been placed under the supervision of a specially trained nurse. This nurse, through long and intimate contact with anesthetized patients and under the guidance of the surgical and anesthesia staffs, can give better nursing care more economically than has hitherto been possible. In the hospital with a school of nursing a valuable educational experience becomes available to the student. The results, according to Dunn and Shupp, (*American Journal of Nursing,* March 1933) have been highly satisfactory.—Sigmund L. Friedman, M.D.

NEWS IN REVIEW

Effect of "Hold-the-Line" Order on Nurses Is Clarified by W.M.C.

By EVA ADAMS CROSS

Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—An announcement on May 14 from the nursing supply and distribution unit, bureau of placement, War Manpower Commission, makes an interpretation, though in no sense complete, of the effect on graduate nurses of the "hold-the-line" executive order 9328 of April 8 and the regulations of the War Manpower Commission of April 18.

Graduate nurses are subject to the terms of the executive order and the War Manpower Commission regulations in exactly the same way as are other workers.

Nursing is an essential activity. This means that in all War Manpower Commission areas:

1. Nurses may move as freely as before within the nursing profession, so long as the job transfer does not bring a higher salary or wage rate.

2. A nurse who is now employed in an activity other than an essential activity may accept a job in the nursing field at any salary or wage rate.

3. Nurses can transfer to new positions which bring a higher salary or wage rate only if they secure statements of availability from their present employers or from the U. S. Employment Service.

There is no prohibition preventing nurses from becoming members of the armed forces.

For information regarding specific local situations, nurses or others concerned are instructed to consult the local U. S. Employment Service office.

A letter dated April 13 from Paul V. McNutt to Dr. Claude W. Munger concerning the essentiality of hospital services bears out the statement on Feb. 12 of Dr. James A. Crabtree published in this magazine in March. Doctor Crabtree, who obtained at that time an interpretation from Mr. McNutt of the "Work or Fight" order, said in part:

"The status of a hospital employe in relation to Selective Service is in no way altered merely by his transfer to some other essential activity, such as aircraft or ordnance production." Certain occupations are nondeferrable regardless of the activity in which they are found.

Eight Los Angeles Hospitals Organize United Hospital Fund

Eight voluntary hospitals in Los Angeles have recently formed a nonprofit corporation known as the United Hospital Fund for the purpose of alleviating the shortages of beds and improving hospical facilities in Los Angeles. In order to accomplish this purpose, the fund will conduct one joint campaign for $3,000,000 to provide approximately 800 beds in the member institutions.

Approximately 300 beds will be made available at once as a result of alterations in existing buildings. The others will be added as soon as major construction is possible.

The funds obtained from the campaign will also be used to provide new equipment and to improve nurses' training school facilities.

The member hospitals of the new organization are: California Lutheran, Hollywood Presbyterian-Olmstead Memorial, Good Samaritan, Methodist, Monte Sano, Queen of Angels, St. Vincent's and White Memorial.

Joint Committee of A.H.A. and Nursing Council Makes Progress

The joint committee of the American Hospital Association and the National Nursing Council for War Service is making substantial progress toward greater harmony and understanding between the nursing and hospital groups, to judge by a statement of functions and program sent out by the council on April 26.

The A.H.A. is represented by James A. Hamilton, Dr. R. C. Buerki, Lt.-Col. Basil C. MacLean and Frank J. Walter. Nursing representatives are Susan C. Francis, Sally Johnson, Bessie Parker, Lucile Petry and Katherine Amberson.

The joint committee will adopt any of the functions of the nursing council as outlined in the March issue of The Modern Hospital that affect both hospital and nursing groups. It will formulate a general interpretative statement; determine which tasks merit priority; suggest studies and make recommendations concerning the problem of supplying adequate nursing service at both the student and graduate level; encourage the increased use of auxiliary services of all types and active participation of hospital administrators in local nursing councils, and promote public acceptance of necessarily restricted war-time nursing service.

Among other recent activities of the nursing council is the appointment of a small steering committee to review the needs for postwar planning for nursing as it affects both foreign relief and home adjustments.

Specialized Training Program Announced by War Department

Washington, D. C.—Basic military training will not be required of Army enlisted men of the Enlisted Reserve Corps who are bona fide preprofessional and professional students and who, when called to active duty, are finally selected for premedical or medical training under the Army Specialized Training program, the War Department announced April 30.

Enlisted Reservists called to active duty from premedical, predental or preveterinary studies will be sent from reception centers directly to Specialized Training and Reclassification Units (S.T.A.R.) without being required to undergo basic military training.

If recommended by selection boards at S.T.A.R. units for continuation of their preprofessional or professional training, they will at the proper time be assigned to appropriate Army Specialized Training units. College premedical and predental students who are not in the Enlisted Reserve Corps and who are inducted into the Army will be transferred to medical department replacement training centers from reception centers in the event that they score at least 115 on the Army general classification test administered to all soldiers at reception centers.

If they are found generally qualified, they will be sent to S.T.A.R. units at the end of their basic training. From these units qualified soldiers will be sent to accredited colleges and universities participating in the Army training program.

Jones Portrait Unveiled

Attended by suitable preliminaries a portrait of the late Col. Percy L. Jones was unveiled in the Hamot Hospital auditorium, Erie, Pa., on April 30. Colonel Jones, who passed away in August 1941, served as administrator of the institution for many years and was prominently identified with hospital work in Pennsylvania.

California Hospitals Urged to Aid Blue Cross Membership Campaign

In an intensive campaign to encourage the hospitals of California to cooperate more fully with Blue Cross plans and to enroll the full quota of subscribers set for the state by the American Hospital Association, the Association of California Hospitals has appointed a special committee to study Blue Cross plans.

In a report issued in April the committee, which is headed by Dr. Anthony J. J. Rourke, Stanford University Hospitals, pointed out that the total Blue Cross enrollment in California in October 1942 was 123,694 and that the quota set for 1943 by the A.H.A. is 300,000. These figures indicate, the report stated, that greatly increased effort on the part of both Blue Cross plans and hospitals would be needed in order to approximate the quota.

The measures recommended by the committee to enable the state to reach its goal include the following:

1. That the board of directors of the association offer all possible assistance to the California Medical Association, which has appointed a similar study committee and employed John Mannix of the Michigan Hospital Service to survey the state regarding medical service and hospitalization organizations.
2. That the board keep member hospitals informed of the steps taken and encourage all hospitals to assist the California Blue Cross plans in arriving at the suggested quotas.
3. That the board authorize Doctor Rourke's committee to apply for a special grant of $2500 from the Rosenberg Foundation or some other philanthropic foundation to further the studies of this committee.
4. That the board authorize the expenditure of all necessary funds to bring the study of the special committee to a successful culmination.

California, Pennsylvania Hospitals Issue House Organs

Two new hospital house organs, from California and Pennsylvania, made their initial appearance within the last month.

The first issue of the *Bulletin* of Pennsylvania Hospital, Philadelphia, is dedicated to the 275 men and women of the hospital who are now serving in the armed forces and contains pictures and news of the activities of these former members of the staff.

Highlights of the *News,* published by the California Hospital of Southern California, Los Angeles, is a report of the formation of the United Hospital Fund.

Ideal CONVEYORS SOLVE BOTH FOOD and PERSONNEL PROBLEMS

SERVING from Ideal Conveyors extends and saves the hospital food supply. Waste is avoided because the food reaches the bedside quickly in its most nutritious and appetizing form. Lower quality grades of food are usable without sacrifice of palatability. The traditional advantages of Ideal service squarely meet today's critical situations in hospital food administration.

Quick mobility of Ideal Conveyors, ease of cleaning, convenience of use save time and labor in all feeding operations. The well-known strength and wear resistance of Ideal units eliminate troublesome repair and replacement problems.

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Built in various models to meet individual requirements. Write for catalog and detailed data on Ideal units now available.

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Los Angeles and San Francisco

The Ideal plant today is dedicated unreservedly to the war effort. All our resources and manpower are being devoted to the needs of the armed forces. Consistent with the greater national requirement, we pledge you our best effort to meet your current needs.

American Ingenuity Will Meet Manpower Problem, Walter States

"I have faith in American ingenuity to meet the difficult manpower problem that American hospitals are now facing," declared Frank J. Walter, president-elect of the American Hospital Association, at the annual convention of the Iowa Hospital Association held in Des Moines on April 27 and 28.

The convention, which previously had taken three days, was condensed into a solidly packed two day session. An interesting and successful innovation was a session on the care of the indigent conducted by the president of the Iowa County Officers' Association with a representative group of county welfare officers in attendance.

Eighty-nine per cent of the nurses now in war service have been taken from hospitals, Mr. Walter stated. To remedy this and other manpower losses, he recommended putting more emphasis on the fact that hospital employes are part of the war effort, holding on hard to teaching staffs, especially in nursing schools, using order 26 of the War Labor Board to raise salaries and improving workers' attitudes by fair wages, hours and time off according to the standards of the community.

A resolution recommending the merging of the two Blue Cross plans in Iowa was passed by the convention.

"Although the voluntary hospitals were in the field first, we must do a broader, better and different kind of a job hereafter if we wish to continue," stated Joseph G. Norby, president of the American College of Hospital Administrators. Among other items he mentioned were greater stress on public health activities, more industrial medicine, broader concepts by boards of trustees of the hospitals' purposes, broader recognition of hospitals as educational agencies.

New officers of the Iowa Hospital Association are: president, Mrs. Grace Hellen, R.N., Sioux Valley Hospital, Cherokee; first vice president, Harold Wright, Methodist Hospital, Sioux City; second vice president, Sister Mary Mercy, Mercy Hospital, Cedar Rapids; secretary, Verne A. Pangborn, University Hospitals, Iowa City; treasurer, Lilyan Zindell, Atlantic Hospital, Atlantic.

A special feature of the meeting was a tribute to Rev. J. P. Van Horn, who will retire on July 1 as superintendent of St. Luke's Methodist Hospital, Cedar Rapids.

Poliomyelitis Unit for Honolulu

An emergency poliomyelitis hospital, the first in Honolulu, has been established on the grounds of the Honolulu Shriners' Hospital for Crippled Children. The buildings were erected last year by the Office of Civilian Defense. Thelma Hensley, R.N., superintendent of the Shriners' Hospital, has been lent to the new hospital as administrator and Dr. Steele Steward, chief surgeon of the hospital, will serve as chief of staff. Food service will be supplied by the Shriners' Hospital. It was agreed by hospital officials that the establishment of the poliomyelitis hospital will not constitute any threat to the patients of the crippled children's hospital inasmuch as the buildings are entirely separate and rigid precautions will be taken.

Waacs Serve in Hospitals

Laboratory and x-ray technicians, dental assistants, hospital orderlies and medical stenographers of the first Waac hospital unit are now serving at the Army Station Hospital at Fort Oglethorpe, Ga. The unit, which has now reached its full strength, is expected to be the forerunner of other Waac hospital units to be sent out to Army posts. In private life several members of the unit were medical secretaries, laboratory technicians, x-ray technicians and pharmacists.

Pathogenic organisms are the proper targets of an antiseptic, yet many bactericidal preparations destroy tissue as well.

• 'S.T. 37' Antiseptic Solution is not only highly bactericidal but clinically non-toxic. This outstanding preparation exerts a soothing local analgesic effect as well.

Moreover, low surface tension enables 'S.T. 37' Antiseptic Solution to penetrate minute tissue spaces, thereby extending the field of its action.

These characteristics make 'S.T. 37' Antiseptic Solution particularly useful in surgical procedures and in treatment or prevention of infection and relief of pain associated with minor cuts, burns, and abrasions.

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'S.T. 37' Antiseptic Solution is odorless, colorless, oil-free, potent in the presence of body fluids—even when diluted several times —and is harmless even if swallowed in full strength. Sharp & Dohme ... Philadelphia, Pa.

'S.T. 37' ANTISEPTIC SOLUTION

OFFICIAL ORDERS
April 15 to May 15

Ascorbic Acid (Vitamin C).—Amendment to Order M-269, May 10, simplifies method of allocating vitamin C. Users in medicines and food products no longer submit form PD-600 to W.P.B. each month but merely place customary purchase orders with suppliers and suppliers make application to W.P.B.

Automobiles.—Professional medical calls, professional calls by public health nurses and sale of essential products are among the essential uses that permit users to buy hard-topped 1942 automobiles costing less than $1500, according to a list issued by O.P.A. on April 26. Executives, technicians and office workers who need cars for travel to hospitals for purposes necessary to the institution's operating also eligible. Persons selling necessary equipment or materials to hospitals also eligible.

Blankets.—Blankets longer than 84 inches will continue to be made for Army and Navy where needed, according to announcement on May 17. Ninety inch blankets are used principally in federal hospitals.

Dehydrated Soups.—In emergency decision made after official point charts for May were printed, O.P.A. temporarily removed from rationing all dried or dehydrated soups.

Proprietary Medicines and Pharmaceuticals.—Packaged drug industry on May 13, placed under a separate price regulation patterned to meet pricing problems resulting from war-time changes and to continue in effect the March 1942 price level. All packaged drugs, covered by new measure. Sales by physicians or other authorized practitioners and sales on prescription not covered by action.

Rubber Gloves.—Distribution of rubber gloves formerly marketed as "seconds" or "rejects" put under W.P.B. control by the issuance of order M-15-h, effective April 30. Such gloves now sold only to fill war orders or to hospitals, clinics, surgeons, physicians, medical schools, dental schools, dentists, morticians, undertaking establishments or schools, morgues, veterinarians or veterinary hospitals or regular dealers.

Rubber Hospital Sundries.—Use of copper in hot water bottles, syringes, ice caps, bulbs and similar rubber hospital sundries restricted but not completely prohibited by the terms of copper order M-9-c, W.P.B. pointed out on April 22.

Scales.—Baby scales can be purchased by general public only on doctor's prescription. Sale of baby scales to physicians, hospitals, distributors and dealers permitted without restriction. Production subject to rigid restriction. Use of copper and brass or of any metal in the tray prohibited. Dietetic scales may be produced for persons whose diet is under a physician's control; purchased on a doctor's prescription.

Shoes.—Nurses' aides needing nurses' shoes can obtain them, according to an announcement from O.C.D. April 28. If a nurses' aide has spent her own stamp 17 and none is available from a member of her family, she may apply to her local board for a special shoe stamp. If she has spent her stamps for nurses' shoes and still needs a pair for general wear, she may make further application to the board for the shoes needed for general wear in such a case.

X-Ray Equipment.—Control over manufacture and distribution of new x-ray equipment extended by amendment on April 28 to order L-206. Beginning June 1, production and shipment must conform to schedules approved by W.P.B. Procedure for extending W.P.B. authorization of purchase forms (PD-556) to suppliers simplified. Amendment also redefines x-ray equipment to exclude stationary grids and bucky diaphragms and to clarify meaning of used equipment. Definition of tube stands modified to exclude supporting and mounting equipment on industrial x-ray machines.

Hospital Given $250,000

Through the will of the late Mrs. Seth K. Ames, New England Deaconess Hospital, Boston, has received a sum totaling $250,000 to be used at the discretion of the trustees for general purposes.

Must have heard about Wyandotte Detergent!

Those half-man, half-horse centaurs in the fables were mighty smart . . . they saw Wyandotte Detergent at work and decided *four*-in-one goes farthest, *fastest!*

It's no myth that Wyandotte Detergent gallops through your cleaning tasks. Or that it does a double *double* job. Packed into this single, speedy standby are the answers to all these maintenance chores:

1. ***Washing painted surfaces.*** **Wyandotte Detergent wipes grime quickly off walls and ceilings, keeps them looking fresh and new.**

2. ***Mopping or scrubbing.*** **Floors become clean in short order with Wyandotte Detergent around. Safeguards against slippery film, too!**

3. ***Cleaning washbowls and sinks.*** **Safe Wyandotte Detergent routs stubborn dirt without danger to delicate porcelain surfaces.**

4. ***Rejuvenating marble floors,*** **walls or fixtures. As a poultice, Wyandotte Detergent draws out even the most ingrained stains.**

If you prefer an *all-soluble* cleaner, try Wyandotte F-100 for floors and walls. And ask your Wyandotte Man to help you untangle any cleaning quandary. He is equipped with short cuts that may well save you time and money.

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• Wyandotte Chemicals Corporation consolidates the resources and facilities of Michigan Alkali Company and The J. B. Ford Company to better serve the nation's war and post-war needs.

Paralysis Foundation Establishes Study Units at Yale and Michigan

With the opening on June 1 of a new three story building at the University of Michigan for a School of Public Health, the National Foundation for Infantile Paralysis and the university will expand to its full scope a long-range program for the study of infantile paralysis and other virus diseases. The program, which has been developing for three years, will include the training of doctors, public health workers and laboratory technicians in combating the whole realm of virus diseases.

To aid in the planning and execution of the project, the foundation has made a three year grant of $120,000, in addition to three previous grants made in the last three years totaling $110,000.

Another grant of $150,000 to establish a unit for the study of poliomyelitis only has recently been made by the foundation to Yale University School of Medicine for the establishment of the Yale Poliomyelitis Study Unit. The school will reorganize its present investigation of poliomyelitis problems and, henceforth, studies will be conducted in the new study unit under the direction of Dr. John R. Paul, professor of preventive medicine.

Construction of Two New Venereal Disease Hospitals Approved

WASHINGTON, D. C.—Presidential approval was given April 29 for the use of federal funds amounting to $80,500 for the maintenance and operation in Richmond, Va., of hospital facilities for the treatment of persons infected with venereal diseases.

The federal grant will supplement funds to be supplied by the city and the U. S. Public Health Service toward the maintenance and operation of a 100 bed hospital for ten months.

The District of Columbia will also have a 100 bed detention hospital for venereal cases, it was announced May 13. Maury Maverick says that the governmental division of W.P.B. has approved construction of a 50 bed addition to the present eye, ear, nose and throat hospital at Gallinger. It will cost $130,400.

Detailed plans of the Suburban Hospital now under construction in Bethesda, Md., have been released. The total capacity of the hospital will be 130 beds. The operation and maintenance will require the services of more than 50 nurses and more than 100 other employes. Provision is made for four nurseries, including one for the care of premature infants and one for infants suspected of having infectious diseases. J. Dewey Lutes is administrator of the new hospital.

The War Department announced on May 6 the awarding of contracts in excess of $1,000,000 each for construction of hospital buildings and facilities at an Army Air Force installation in Grant County, Washington, the work to be supervised by the Seattle District Office of the Corps of Engineers, and for the construction of an Army general hospital in Okmulgee County, Oklahoma. Clyde M. Ludberg Company, Spokane, Wash., and Cowen Construction Company, Shawnee, Okla., are the contractors.

Further announcement on May 11 by the War Department disclosed the fact that hospital buildings and facilities are to be constructed in Liberty County, Georgia, and in San Diego County, California.

The former will cost somewhere between $500,000 and $1,000,000, the latter, less than $50,000. The contract in the first instance was awarded to Claussen and Webster, Augusta, Ga., and in the second, to Brock-Brady, San Diego, Calif.

Such language!

My boss used to be as grumpy as a bear. He'd growl and bang around and his wife said: "Poor George, he's working too hard. It's wearing him down to a frazzle!"

So, I told her a few plain facts:

. . . how I'd discovered the most amazing thing . . . that physicians who prescribe S-M-A* actually have more time for other things . . . because it isn't necessary to change the formula throughout the entire feeding period. (She sat up at that.)

. . . how S-M-A eliminates many unnecessary questions that mothers usually ask about other modified milk formulas.

When I had finished, she said she would certainly speak to George about using S-M-A as a routine formula.

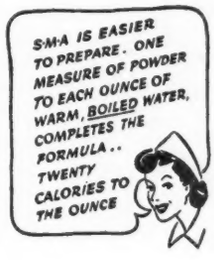
★ ★ ★

Just because my boss turned over a new leaf . . . he wants everybody to pat him on the back for it. But he's not fooling us . . . we know how he got to be such a nice man.

BUSY DOCTORS TODAY—PRESCRIBE S-M-A!

With the exception of Vitamin C . . . S-M-A is nutritionally complete. Vitamins B_1, D and A are included in adequate proportion . . . ready to feed. Their presence in S-M-A prevents the development of subclinical vitamin deficiencies . . . because the infant gets all the necessary vitamins right from the start.

S-M-A has still another highly important advantage not found in other modified milk formulas. It contains a special fat that resembles breast milk fat . . . resembles it chemically and physically—according to impartial laboratory tests. S-M-A fat is more readily digested and tolerated by most infants than cow's milk fat.



The infant food that is nutritionally complete

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S-M-A, a trade-mark of S.M.A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

Los Angeles County Hospital Establishes 700 Bed Pay Unit

To meet the stringent shortage of hospital beds for paying patients in Los Angeles, the Los Angeles County General Hospital has equipped 700 beds in a pay bed unit. This will be served by the regular medical staff of the hospital.

Patients will be admitted only after the voluntary hospitals have certified that no beds are available. The patient will pay the regular fee of the physician and the money will be put into a special research fund to be administered by joint agreement of the two medical schools that use the hospital for teaching purposes.

OUR NEW ADDRESS

Under the new zoning regulations adopted by the Post Office Department for 178 of the larger cities, the address of The MODERN HOSPITAL is now 919 N. Michigan, Chicago 11, Illinois. Readers are requested to use this address in all correspondence.

97 Per Cent of Wounded Recover

More than 97 per cent of Navy and Marine Corps fighters who were wounded between the attack on Pearl Harbor and March 31, 1943, have recovered, it has been announced in an O.W.I. report. Only 2.6 per cent of all Navy and Marine wounded died subsequently; 53 per cent were returned to duty; 0.9 per cent were invalided out of service, and 43.5 per cent were still under treatment as of March 31. Credit for the amazing recovery rate is given to the medical care and equipment that are available to our fighting men, ranging from the first-aid kit that is a part of each man's equipment to the general, or base, hospitals far removed from the battle area.

Men Wanted!

An appeal for men volunteers to serve as orderlies for three hours two nights a week has been issued by New York Hospital, New York City. After attending training classes, the volunteers would perform for male patients tasks comparable with those of the women nurses' aides. The hospital already has 10 men serving as orderlies and five other male volunteers, two serving in the pharmacy, two in the x-ray department and one in the personnel department. Hospital officials hope that at least 140 business and professional men will volunteer for this service.

50 Register for Michigan Institute

More than 50 persons registered for the Institute on Public Health Economics arranged by the School of Public Health of the University of Michigan for May 10 to 22. Included were persons affiliated with Blue Cross plans, medical service plans, hospitals, U. S. Public Health Service, U. S. Children's Bureau, cooperative societies, Farm Security Administration, foundations, private group clinics and city and state health departments. The faculty and guest lecturers included 41 authorities.

West Virginia Elects Officers

New officers elected at the annual meeting of the Hospital Association of West Virginia, May 3 and 4, were as follows: president-elect, Dr. A. F. Lawson, director, General Hospital, Weston; vice president, Supt. E. A. Groves, Kanawha Valley Hospital, Charleston, and secretary-treasurer, Charles E. Vadakin, superintendent, Fairmont General Hospital, Fairmont. Dr. Dean L. Hosmer, superintendent of Bluefield Sanitarium, Bluefield, was inducted as president.

54 Bed Addition Granted

An AA-3 priority rating has been granted by the Federal Works Agency to Perth Amboy General Hospital, Perth Amboy, N. J., for materials for a 54 bed addition to the existing hospital. The new two story and part basement addition will be of brick construction with wood floor joists. The use of critical materials will be cut to a minimum. The new quarters will contain additional beds, operating and laboratory facilities, a delivery room and kitchen and laundry space. A Lanham Act grant of approximately $101,000 has been provided.

Coming Meetings

June 12-14—Catholic Hospital Association, William Penn Hotel, Pittsburgh.
June 15-17—National League of Nursing Education, Chicago.
June 22-24—Special Libraries Association, Hotel Pennsylvania, New York City.
June 29-30—Maritime Hospital Association, Cornwallis Inn, Kentville, N.S.
Sept. 13-17—American Hospital Association, Hotel Statler, Buffalo, N.Y.
Oct. 12-14—American Public Health Association, New York City.

Eastman Urges Travel Reduction

Government officials who are asked to speak at conventions have been urged by Joseph B. Eastman, director of O.D.T., to examine such requests carefully before accepting them. Mr. Eastman also asked that all government business travel be reduced to a minimum in keeping with the O.D.T.'s general program of conserving transportation facilities. "The federal agencies can be of great help in this campaign by setting an example in travel conservation to the public," Mr. Eastman stated.

Mount Pleasant Hospital Dedicated

Ceremonies dedicating the Central Michigan Community Hospital, Mount Pleasant, Mich., were held on April 2. The hospital was built with the help of the Commonwealth Fund which made a grant of $225,000 for building and equipping it. Originally planned to be completed by June 1942, the structure was delayed by war-time restrictions on building materials. Barry C. Smith, general director of the Commonwealth Fund, was one of the principal speakers at the dedication.

Institute Receives Endowment

The construction of a two story building to house the Toledo Hospital Institute of Medical Research, Toledo, Ohio, has been made possible by an endowment by the late Frank Collins of the National Supply Company. The staff of the institute now comprises a biochemist, nutritionist, bacteriologist, pathologist and biophotographer under the direction of Dr. Bernhard Steinberg and will be augmented by a physiologist, biophysicist and pharmacologist. Provision has been made to accept fellows in medical and dental research.

College to Train Student Nurses

Approval has been given for a grant of $170,000 for the construction and equipment of a dormitory for 100 student nurses at Adelphi College, Garden City, Long Island, it was announced on April 13. Adelphi College is one of seven in New York State that have been selected to carry out an emergency project for nursing education. Students will be able to obtain a registered nurses' certificate after thirty months of study and a B.S. degree after thirty-nine months.

Kenny Center Opened

The Crippled Children Services of the Louisiana State Board of Health in cooperation with Charity Hospital, New Orleans, has recently put a Kenny Method Treatment Center into operation at the hospital. The management of cases will be taken care of by members of the faculties of Tulane University, Louisiana State University and the independent staff of Charity Hospital.

X-Ray Mental Patients for Tuberculosis, Parran Urges

WASHINGTON, D. C. — Routine x-ray examination of patients in the admitting rooms of general hospitals and state hospitals for the mentally ill was recommended by Dr. Thomas Parran, surgeon general of the U. S. Public Health Service, on March 31.

Since the outbreak of the war, the Public Health Service has given x-ray examinations for tuberculosis to nearly a quarter of a million people, said Doctor Parran recently. More than 160,000 workers in war industries located in nine states and some 40,000 federal employes in the District of Columbia were included in this number.

There is no apparent increase in the incidence of this disease since the war began, Doctor Parran asserted, but in the congested war areas the circumstances favoring such increase are much in evidence.

Plasma Therapy Training Offered

Up-to-date information concerning blood plasma therapy and whole blood transfusion is to be given to New York State physicians in a group of special lectures sponsored by the Medical Society of the State of New York, the state department of health, the Office of Civilian Defense and the state health preparedness commission. The speakers, who are now ready to give lectures and demonstrations to county medical societies and hospital staffs, are physicians who have had special instruction in the subject. Expenses of the speakers are paid by the medical society and the state department of health. Further information on the program can be obtained from Dr. O. W. H. Mitchell, 428 Greenwood Place, Syracuse, N. Y.

Paterson Adds 150 Beds

Through the conversion of the former plant of the Paterson Orphan Asylum, the capacity of Paterson General Hospital, Paterson, N. J., will be increased by 150 beds. The new addition will house the complete maternity and children's departments; the plans call for 100 maternity and 50 children's beds and infants' bassinets. This constitutes a war public works project estimated to cost, with the acquistion of the orphanage, about $550,000 of which $375,000 will be in a federal grant of the Lanham Act funds. Frederick Vreeland is the architect.

Hospital Named for McCloskey

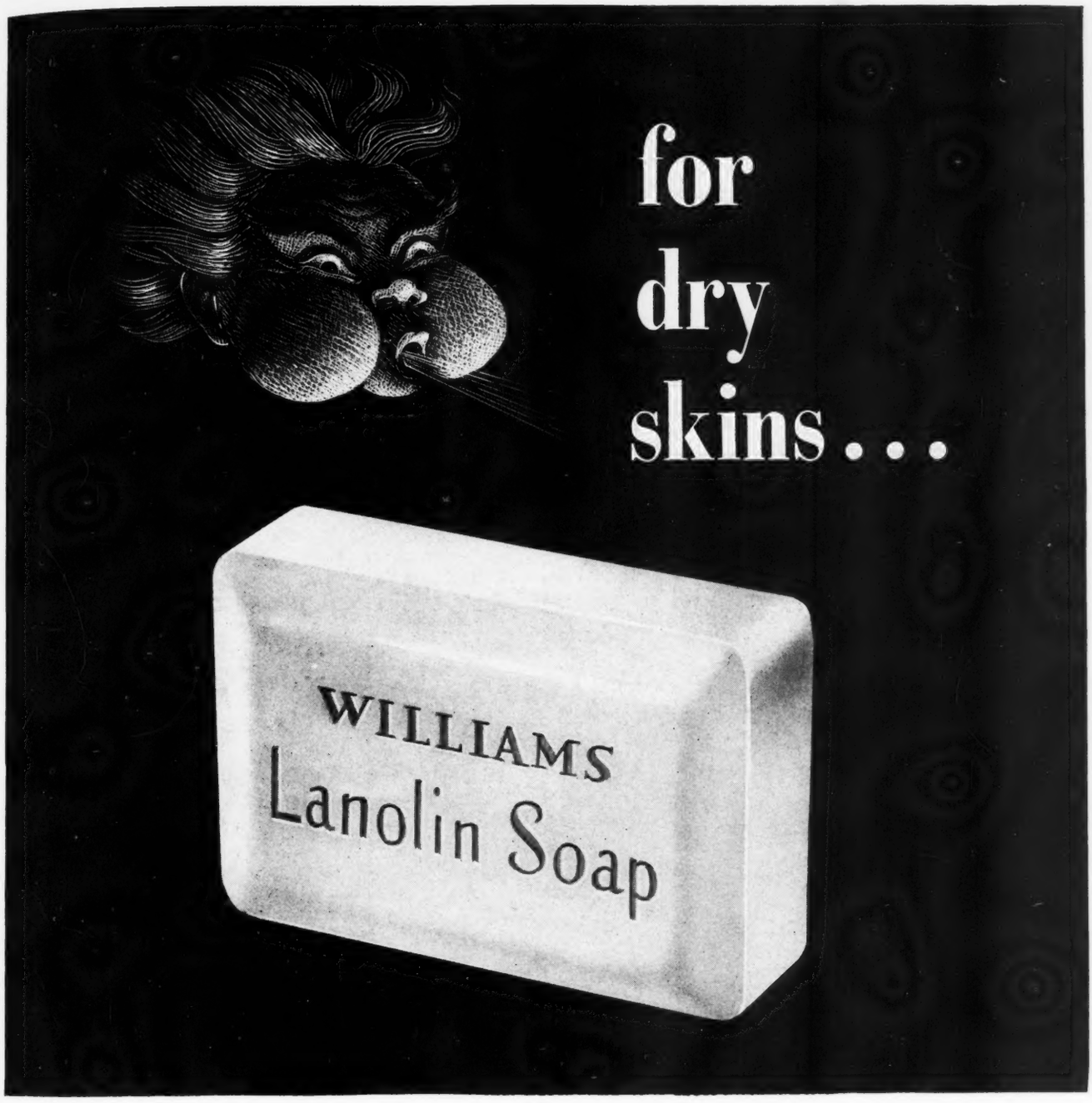
In honor of the late Maj. James R. McCloskey, M.C., first regular Army medical officer to lose his life in the war with Japan, the U. S. Army hospital at Temple, Tex., has been named McCloskey General Hospital. Major McCloskey died at Bataan in March 1942. The hospital has a capacity of 1500 beds at the present time and a second 1500 bed unit is now under construction.

Valley Forge Hospital Opened

The new U. S. Army Valley Forge General Hospital was opened recently at Phoenixville, Pa., with Col. Henry Beeuwkes as commanding officer. The hospital has a capacity of 2000 beds in two story brick structures connected by hallways. The administrative work of the institution is carried on by 23 medical administrative, quartermaster, engineer and finance officers.

Hospital Is War Casualty

Loss of 15 staff physicians who were called into the armed services forced the closing of Riverview Hospital, Norristown, Pa., on March 1. Stockholders and directors voted to dissolve the corporation, which had been in operation since 1929. The land and buildings will be sold.



TOP-QUALITY U. S. P. lanolin — plus exceptional blandness — recommend Williams Lanolin Soap for bathing dry skin.

No fatty acids, dye or strong perfume are present in Williams Lanolin Soap. The oils are as fine as money can buy and are used in a way that precludes injurious rancidity. Uncombined alkali is virtually non-existent.

Williams Lanolin Soap lathers quickly and abundantly—rinses completely. Since it is subjected to high pressure, it is long-lasting, economical. Delicately scented and colorfully wrapped, Williams Lanolin Soap appeals to patients as a high-grade complexion soap.

Let us send you a full-size cake of Williams Lanolin Soap with our compliments. Then you can observe its advantages in use. No obligation, of course.

**The J. B. Williams Co., Dept. SB-07,
Glastonbury, Conn.**

Please send me a full-size cake of Williams Lanolin Soap.

Name_____

Address_____

City_____ **State**_____

This offer is restricted to the medical and nursing professions. Please attach letterhead, card or other professional identification. Good only in U.S.A.

Use of Overlapping Internships to Solve Shortage Is Urged

The utilization of overlapping internships resulting from the nine month school year to overcome the shortage of medical personnel was urged recently by the directing board of the Procurement and Assignment Service.

Nearly all medical schools now have a graduating class every nine months, it was pointed out, and a full year of internship is required by Army and Navy regulations, by many state boards and, in some instances, by medical schools. In March and April new groups of interns are entering hospitals that also have interns from the previous year.

It is the consensus of the various medical associations that there would be no objection to permitting interns to transfer from the hospital in which they had completed nine months' service to another institution that had need of interns to serve out their remaining three months. These transfers would be made only to approved hospitals that do not have adequate personnel and only if the hospital in which the first part of the internship was served would certify to a full year's service.

Hospital Corps Accepts Waves for All General Medical Service

WASHINGTON, D. C.—Waves are now permitted to become naval hospital corpsmen, declared a spokesman for the Bureau of Medicine and Surgery, U. S. Navy, in an interview April 16. They were being enrolled as early as January as technicians in the hospital corps. Now, however, they are accepted for general service in all the medical department activities within the continental limits of the United States. They are not accepted for foreign duty or for service on ships.

With seven U. S. fleets afloat, every Wave thus enlisted frees a man who can serve on these ships and it is hoped that substantial numbers of them will enter the hospital corps.

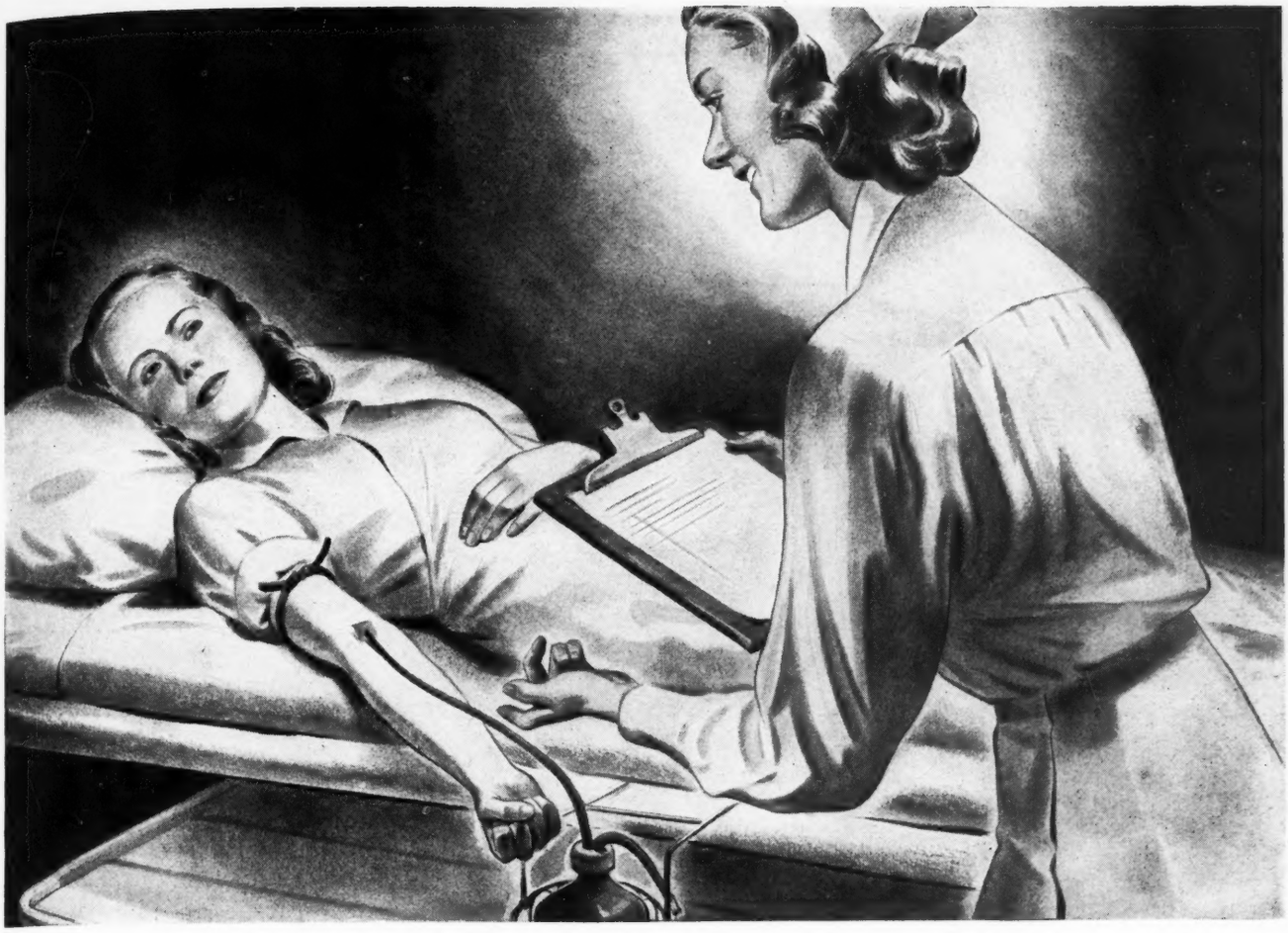
A new educational program for the corps has been planned to shorten and standardize all training courses, it was reported. The mounting need for hospital corpsmen who serve aboard ships at sea, in continental and overseas hospitals and with Marine units has necessitated this shortening of the training period.

Booklet on Goldwater Published

A booklet of resolutions and appreciations of Dr. S. S. Goldwater was published in April by Mount Sinai Hospital, New York City, as a reprint from the hospital's *Journal*. Resolutions include those by the New York City Council and the trustees, medical board, junior medical staff and associated alumni of the hospital. Appreciations given at the memorial services at the Ethical Culture Meeting House on October 24 include those by Dr. George Baehr, Newbold Morris and Algernon D. Black. Magazine notices from The MODERN HOSPITAL, *Hospitals, Hospital Progress* and the *Quarterly Bulletin* of the New York City Department of Health are included. An editorial from the *New York Times* is also reprinted and an article by Dr. Joseph Turner giving an intimate picture of Doctor Goldwater and quoting many of his exchanges of poetry with his friends.

Salaries, Hours Increased

Legislation enabling employes of New York State mental hospitals to volunteer for over-time employment with additional pay until April 1, 1944, was enacted by the state legislature to relieve the manpower problem in these institutions. The action was taken on the recommendation of Gov. Thomas E. Dewey that persons at present employed in mental hygiene institutions be permitted to volunteer for four hours' over-time work at the regular rates of pay. The legislature also enacted salary increases for state employes in the lower income brackets.



"It reaches from here to the battlefront"

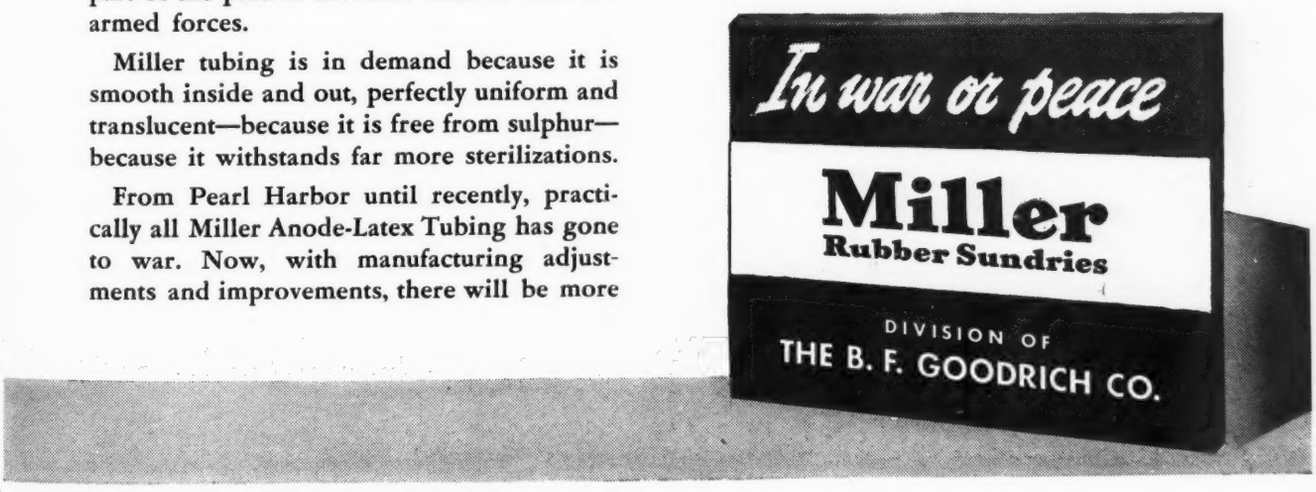
Seventy thousand pints of blood a week are needed to meet war demands for life-saving plasma—nearly three times as much as was donated last year.

This means greater need for Miller Anode-Latex Intravenous Tubing—for this tubing already has been playing an important role in the blood donor centers, and also as a vital part of the plasma kits now abroad with our armed forces.

Miller tubing is in demand because it is smooth inside and out, perfectly uniform and translucent—because it is free from sulphur—because it withstands far more sterilizations.

From Pearl Harbor until recently, practically all Miller Anode-Latex Tubing has gone to war. Now, with manufacturing adjustments and improvements, there will be more for use here at home. If you have believed that, because of war, it was necessary to put up with less efficient tubing—you'll be glad to know that there's now enough Miller Anode-Latex Tubing to "reach from here to the battlefront."

Miller Rubber Sundries Division of The B. F. Goodrich Co., Akron, Ohio



Turn in Steel Ampule Files

Physicians and pharmacists are being requested by the Schering Corporation to turn in all unused steel ampule files in an effort to conserve steel and to ensure sufficient files to meet future needs. Physicians are asked to send in their excess supply of files to pharmacists and dealers in a special envelope that is provided by the manufacturer. All files that are turned in will be tested and sorted and those that are still in good condition will be redistributed to physicians as the need arises. Files that can no longer cut satisfactorily will be contributed to the scrap metal drive.

Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

U. S. ARMY

Robert Bachmeyer (2nd Lt.), Office of Civilian Defense.

Ernest G. McKay (Capt.), Tampa Municipal Hospital, Tampa, Fla.

T. Harvey McMillan, McMillan Hospital, Charleston, W. Va.

James Sexton (2nd Lt.), Administrative Intern, Oakland, Calif.

U. S. NAVY

Kenneth H. Gordon (Lt.), Greene County Memorial Hospital, Waynesburg, Pa.

Effects of War on Medicine to Be Studied by Committee

Appointment of a committee of distinguished physicians and laymen to study the relationship of medicine to the social and economic changes of the present era was announced by the New York Academy of Medicine on April 18.

John W. Davis, Democratic candidate for president in 1924, and W. S. Gifford, president of the American Telephone and Telegraph Company, are the laymen. There are 18 physicians, including Malcolm Goodridge, chairman, Iago Galdston, secretary, George Baehr, James Alexander Miller, Alan Gregg, Wilson G. Smillie and Jean A. Curran.

The committee will consult deans and faculties of medical schools, hospitals and public health authorities, persons interested in graduate education, industrial and other physicians, medical social workers, workers in voluntary health organizations, sociologists, economists, labor leaders, industrialists, bankers and politicians.

"The committee will devote itself primarily to the study of how, within the changing social order, the best qualities of medical service, medical education and medical research can be preserved and developed," the announcement stated.

U.S.P.H.S. Reorganization Urged

WASHINGTON, D. C.—Reported to the Senate by its Committee on Education and Labor is S. 400, administration-requested legislation, to reorganize and enlarge the functions of the U. S. Public Health Service. The present organization of eight administrative divisions reporting directly to Surgeon General Thomas Parran would be changed into four: the office of the Surgeon General, the National Institute of Health, the Bureau of Medical Services and the Bureau of State Services.

Public Health Fellowships Granted

Funds have been granted by the W.K. Kellogg Foundation to the U. S. Public Health Service for the establishment of 20 fellowships leading to a master's degree in public health with a major in health education. Fellows will be granted stipends of $100 per month plus tuition and will be given nine months of intramural training and three months of supervised field experience.

Hospital School for Waves

Waves assigned to the Navy hospital corps will be trained at a school to be established at the Naval Medical Center, Bethesda, Md. Construction of the school, which will accommodate 500 students, is expected to start soon.

RIP VAN WINKLE SLEPT *SO-O-O* SOUNDLY

● Old Rip was the sleepingest man of his day. He had no competition for the title. No, Rip didn't worry about his competitors —and so he could sleep for twenty years.

● Things today are different. Today modern institutions must think of the things that will keep them in the race for public favor. Wise hospital management knows that Vollrath kitchen and clinical ware is so distinctive, so practical and so serviceable that it *helps* gain public and professional approval. Knowing this, hospitals from Coast-to-Coast insist upon Vollrath Ware throughout. They know that Vollrath is designed for beauty and utility and is built for long life.

Vollrath Nu-Steel Liquid Cleaner

Porcelain Enameled Forceps Jar

Stainless Steel Measure

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Genuine Vollrath Ware Bears This Label

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NAMES IN THE NEWS

Administrators

Leighton M. Arrowsmith, for many years administrator of St. John's Hospital, Brooklyn, N. Y., has resigned his post with that institution. E. Reid Caddy, former director of South Baltimore General Hospital, Baltimore, Md., has been named to succeed Mr. Arrowsmith. In addition, Mr. Caddy will be director of the Church-Charity Foundation, including the Home for the Blind and Home for the Aged.

J. C. Lund, former secretary and business manager of schools at Minot, N. D., has recently accepted the position of superintendent of Trinity Hospital in that city.

H. A. Cross has resigned his position as executive director of the Jewish Hospital, Louisville, Ky., to accept a position as administrator of Good Samaritan Hospital, West Palm Beach, Fla.

Jacob H. Trayner, for the last nineteen years administrator of Idaho Falls Latter-Day-Saints Hospital, Idaho Falls, Ida., has resigned his position.

Dr. Ole C. Nelson, formerly assistant warden of Cook County Hospital in Chicago, has been named medical director of the hospital, succeeding **Dr. Marshall Davison,** who resigned recently. Doctor Nelson's appointment becomes effective on June 1.

Robert B. Graves has been appointed administrator of Grant Hospital, Chicago. Mr. Graves has been associated with the hospital since 1939, first as public relations director, then as purchasing agent and later as assistant superintendent.

Dr. J. R. Saunders has been appointed administrator of the State Hospital at Morganton, Morganton, N. C. Doctor Saunders was formerly assistant superintendent of the institution.

Mrs. Lewis M. Miller is the new administrator of Rowan Memorial Hospital, Salisbury, N. C.

Dr. Eugene L. Sielke is the new administrator of Danville State Hospital, Danville, Pa. Formerly, Doctor Sielke was assistant superintendent of Philadelphia State Hospital.

James Sexton, a graduate of the University of Chicago course in hospital administration, and former adminstrative intern at Alameda County Hospitals, Samuel Merritt Hospital and Peralta Hospital in Oakland, Calif., has reported at Carlisle Barracks, Carlisle, Pa., as second lieutenant.

T. Harvey McMillan, administrator of the McMillan Hospital, Charleston, W. Va., recently reported at Carlisle Barracks.

Harold Kovner, superintendent of Park East Hospital, New York City, has been elected to the board of directors of the Associated Hospital Service of New York.

Ernest G. McKay, formerly administrator of Tampa Municipal Hospital, Tampa, Fla., is now a captain in the Army Medical Administrative Corps.

Abraham Oseroff, director of Montefiore Hospital, Pittsburgh, for the last fifteen years, has resigned to devote his full time to the Hospital Service Association of Pittsburgh of which he is vice president and general manager.

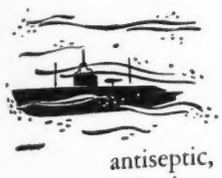
M. J. Russell has been appointed acting superintendent of the Laguna Honda Home, San Francisco.

Ruth E. Johnson, R.N., has been selected as administrator of the Woodstock Public Hospital, Woodstock, Ill. She succeeds **Hilda Whitefoot.**

Myrtle Kvenvold, R.N., has been named administrator of Waseca Memorial Hospital, Waseca, Minn.

Martha B. Rettig has assumed the duties of administrator of Burge Hospital, Springfield, Mo.

Kenneth H. Gordon, superintendent of Greene County Memorial Hospital, Waynesburg, Pa., has joined the Navy as deck volunteer specialist and lieutenant, senior grade. At present Mr.



The wardroom of a U. S. submarine in enemy waters... a seaman is down with acute appendicitis. With a tea strainer for an anesthetic cone, and alcohol drained from torpedoes for antiseptic, an operation is performed, successfully, in two hours.

Under such circumstances, naval surgeons—and the physicians of the Army Medical Corps—are providing medical care for our fighting forces with a skill and ingenuity seldom, if ever, seen. From field dressing stations and ships' sick bays from Tunisia to Tulagi come reports of victories over disease and death of which the medical profession may well be proud.

At the doctor's call in this war, thankfully, are new sulfa and other drugs which ease pain, prevent infection and save human life, as well as revolutionary advances in surgery. And of course, there are the "old standby" medical aids, among them U.S.I. Pure Alcohol, which have served the cause of medicine so faithfully for so many years—these, too, are playing a part in America's wartime medical service.

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21 IMPORTANT HOSPITAL USES FOR ALCOHOL

- ☐ Compounding Prescriptions
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- ☐ Dehydration of Pathological Sections
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- ☐ Hypodermic Injections
- ☐ Massage and Sponge
- ☐ Pharmaceutical Preparations
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- ☐ Stains and Reagents
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- ☐ Sterilizing Skin
- ☐ Surgical Soap Preparation
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- ☐ Therapeutic Nerve Block

U.S.I. Pure Alcohol is, of course, still available for hospital use on the home front. Check your requirements for alcohol with this convenient list of 21 major hospital applications... and specify U.S.I. Pure Alcohol for every use.

PURE ALCOHOL

Gordon is stationed at Columbia University. **J. Thomas Lindbergh** has been named to succeed him at the hospital.

Lucille E. Long is the new administrator of City Hospital, Rushville, Ind.

Mrs. Esther Hamilton Murphy, R.N., has been appointed administrator of Fairview Hospital, Great Barrington, Mass.

Department Heads

Sara Hamilton, former administrative assistant at Charlotte Memorial Hospital, Charlotte, N. C., has recently accepted the position of superintendent of nurses at Winchester Memorial Hospital, Winchester, Va.

Arthur M. Thompson has been selected as chief pharmacist at Newton Hospital, Newton Lower Falls, Mass. Mr. Thompson was formerly associated with the New England Deaconess Hospital in Boston.

Ethel Gilbert has resigned as associate professor of nursing at the Medical College of Virginia, Richmond, to become director of nursing at Christian H. Buhl Hospital, Sharon, Pa.

Gertrude Thompson, assistant director of nursing service at the Medical College of Virginia, will be the new director of nursing at the Chesapeake and Ohio Railway Hospital, Clifton Forge, Va.

Elinor Mathilde Palliser has recently been appointed superintendent of nurses at Vancouver General Hospital, Vancouver, B. C.

Miscellaneous

Lucile Petry has been appointed the first dean of Cornell University-New York Hospital School of Nursing. Formerly Miss Petry was senior public health nursing consultant of the U. S. Public Health Service.

Mrs. Edna Huffman is now in charge of the medical records library at Wesley Memorial Hospital, Chicago.

Edna H. Smith has been selected as dean of the Syracuse University School of Nursing, Syracuse, N. Y., which will open June 28. Formerly a professor of nursing and director of nursing service at Stanford University Hospitals, Miss Smith has recently been special recruitment consultant of the National Nursing Council for War Service.

Dr. Victor E. Johnson, dean of students at the University of Chicago School of Medicine, has been appointed secretary of the A.M.A. Council on Medical Education and Hospitals to succeed **Dr. H. G. Weiskotten.**

Frank P. Sauer has been appointed business assistant of Grasslands Hospital, Valhalla, N. Y.

Dr. Charles E. Remy is the new hospital consultant for the hospital facilities section, U. S. Public Health Service, Washington, D. C. Doctor Remy has received a commission as surgeon in the reserve corps of the Public Health Service.

Robert Bachmeyer, formerly with O.C.D., is now a second lieutenant with the Army Medical Administrative Corps and is stationed at Carlisle Barracks, Carlisle, Pa.

Bernice M. Wilbur of Boston, director of the Army nursing service in North Africa, has been promoted from first lieutenant to lieutenant-colonel, giving her the same rank as that held by directors of nursing services in the European and Southwest Pacific theaters.

Deaths

Rev. J. H. Groseclose, administrator of the Methodist Hospital of Dallas, Dallas, Tex., died May 9 while driving home from a commencement service. Doctor Groseclose was a trustee of the American Hospital Association, a charter fellow and regent of the American College of Hospital Administrators and president of the Group Hospital Service of Texas.

Dr. Mont R. Reid, head of the surgical departments of the University of Cincinnati Medical College and General Hospital, died recently at his home.

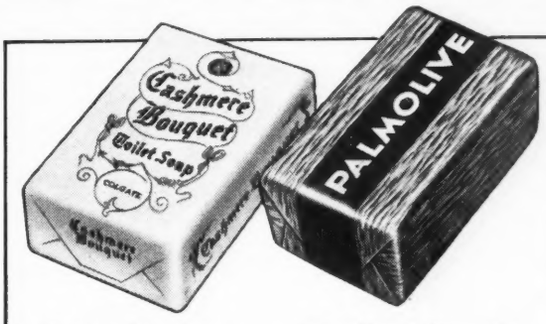
Here's The Floating Soap For Hospital Use That Pleases 3 Ways!

In Purity...In Mildness...In Economy ...No other soap is better suited to Hospital use than Colgate's Floating!

WHEN is a soap "just right" for patient care? We believe you'll find the answer when you try Colgate's Floating Soap—*the soap made specially for hospital use!*

In purity, Colgate's Floating meets the most rigid requirements. Its mildness, and its rich abundance of fast-cleansing, gentle lather have made Colgate's Floating a strong favorite with nurses and patients alike. Its economy has made it an equally strong favorite with hospital superintendents, for Colgate's Floating Soap is easy on budgets!

Ask for prices on Colgate's Floating Soap in the sizes and quantities you need. See your local Colgate-Palmolive-Peet representative; or write direct to our Industrial Department at Jersey City, New Jersey. You're under no obligation, of course, in either case. Why not do this today?



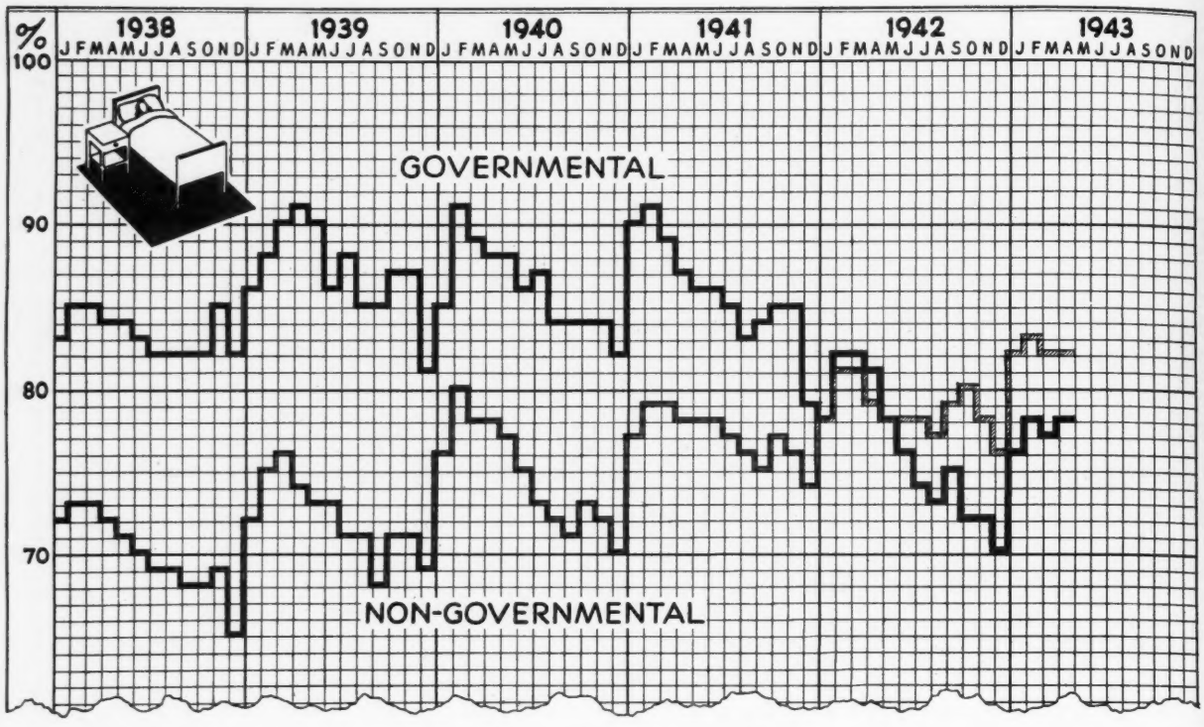
For use in private pavilions, and particularly for women patients, we recommend Cashmere Bouquet. A fine, white, hard-milled soap, it is famous for its rich, creamy lather... its delicate, lingering perfume! Available in miniature sizes.

Palmolive is becoming increasingly popular among hospitals, both for staff use and for patient care. The world's largest selling toilet soap, it meets the highest hospital standards in purity. Palmolive, too, comes in miniature sizes.

COLGATE-PALMOLIVE-PEET CO.

INDUSTRIAL DEPARTMENT, JERSEY CITY, N. J.

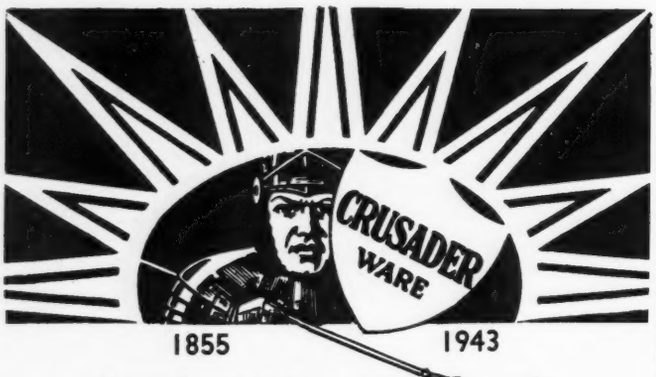
Voluntary Hospital Occupancy Continues to Soar



Continued high occupancy in the voluntary hospitals was reported for April, while governmental general hospitals maintained a level five points lower.

This was the highest April on record for the voluntary hospitals and the lowest for the governmental group.

A total of 19 new hospital construction projects valued at $8,822,750 was announced in the period from April 19 to May 17. The total for the year to date is $66,500,000. Projects postponed since January 1 involved a total of $18,000,000, leaving a net for the year of $48,500,000.



Crusader stainless utensils result from eighty-eight years of manufacturing leadership.

Made of chrome - nickel - steel alloy, these fine wares are accepted as standard by leading buyers because of their rust and acid resistance. Though not now produced for ordinary uses Crusader Wares will be available again when conditions permit.

Meanwhile, in the fourth war in Company history, its workers and manufacturing facilities are faithfully serving our country in the production of equipment for war use.

LALANCE & GROSJEAN MFG. CO.
WOODHAVEN, NEW YORK

- **Safe**
- **Modern**
- **Satisfactory**

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CONTINENTAL PARENTERAL SOLUTIONS

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CLOSED TECHNIQUE METHOD OF ADMINISTRATION

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INCREASE YOUR BED CAPACITY WITHOUT INCREASING THE SIZE OF YOUR HOSPITAL!

This can be done easily and cheaply, and without disrupting the routine of your hospital, with ARNCO BED SCREENING by turning private rooms into semi-private rooms, and adding beds to your semi-private rooms and wards.

Prepare now for increase in number of patients due to present emergency. Simply send us a rough sketch of your rooms and wards, and our engineering department will send you complete information and costs.

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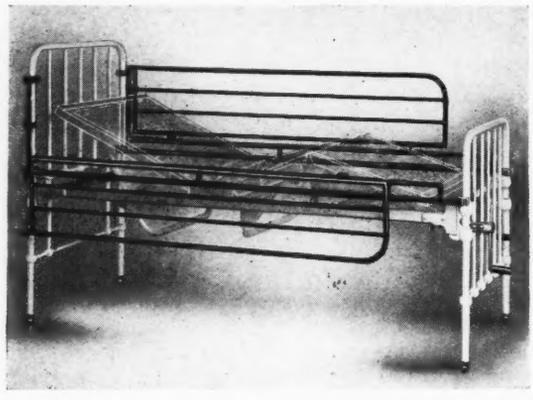

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Sizes to fit any bed. Have rigidity of single piece sides—but for easy access the drop section can be pulled down with one hand. Forked ends allow easy attachment and removal . . . and are leather lined to protect bed finish. In ordering, specify length of bed, diameter of posts and plain color required.

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Offices: 118-122 Baxter St. **New York City** Salesrooms: 200 Madison Ave.
Member of Hospital Industries Association

Introducing

...a New Ethyl Chloride CONTAINER and DISPENSER

CAREFULLY packed in individual cartons, these Ethyl Chloride bottles contain 100 grams each and are available for prompt delivery. Place a supply in your operating room and earn the gratitude of your anesthetists for your thoughtfulness in providing such a convenient dispenser.

The many advantages of this new container and dispenser for Ethyl Chloride are apparent at a glance.

1 The design of the glass bottle fits the hand perfectly.

2 The release lever is in exactly the right position for the thumb tip.

3 The position and shape of the outlet make possible the use of every drop of the contents.

4 The jet release is constructed of metal with glass capillary flow tube. A rubber stopper held against the tube end by spring tension, prevents leakage and evaporation.

5 The broad base keeps the center of gravity low so that accidental tipping is minimized.

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POSITIONS WANTED

ADMINISTRATOR-BUSINESS MANAGER—Serving my 21st year as assistant administrator and purchasing executive in large eastern hospital; wish to secure position in medium size institution; I am draft exempt. MY 504, The Modern Hospital, 919 N. Michigan Avenue, Chicago.

ADMINISTRATOR—Degree from eastern university; excellent background in business before entering administrative field; nine years, administrator, 350-bed hospital; active in affairs of hospital field; F.A.C.H.A.; for further details, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

ADMINISTRATOR—Graduate nurse with proven record of successful experience in administration; has held important appointments in nursing and hospital organizations; recommended as outstanding executive with marked organizing ability; expert in public relations; for further details, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

ADMINISTRATOR—Male, outstanding as to length of service and quality of work; accomplished in every phase of hospital administration; untiring, always willing to assume additional responsibilities; interested in large hospital any location, though prefer south or southwest. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

ANESTHETIST—Eight years experience in all inhalation, rectal, intravenous anesthesia; interested in heading department of anesthesia large hospital, or as assistant superintendent of nurses-chief anesthetist, all graduate hospital. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

DIETITIAN—Or Steward large institution; age 44, college education; five years in food and market research; four as chief administrative dietitian 1200-bed institution; highly recommended, interested in either position. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

DIRECTOR OF NURSES—B.S. Degree, western university; M.A. Degree, eastern university; professionally trained in one of the country's most important teaching hospitals; public health training and experience for several years; assistant director of nurses, three years, and director of school and nursing service, four years, university group; for further information, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

DIRECTOR OF NURSES — Assistant; B.S. Degree, nursing administration, June 1943; age 30; supervising experience; qualified as second assistant in nursing office. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

EXECUTIVE—R.N., with ten years experience, mostly in children's hospitals; eight years' business experience prior to nurses' training; has ability, character, is alert to progressive ideas, has rare executive ability. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

MEDICAL ANESTHETIST — Young woman physician; degrees from leading schools; rotating internship was supplemented by three-year residency in anesthesiology; for further details, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

PATHOLOGIST—Diplomate American Board, is available; past several years director laboratories, two hospitals and associate in pathology, university medical school; age 32; non-incapacitating physical disability; for further details, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

PHYSICAL THERAPIST—Ten years' experience as physical therapist; past several years, head of physical therapy, university hospital; registered; for further details, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

RADIOLOGIST—Diplomate American Board; three years' graduate training; several years' important experience; retired officer, not likely to be recalled (minor disability); age 47; for further information, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

RESIDENT—Young physician completing internship July 1, would like residency affording training in surgery; disqualified for military service; for further details, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

SUPERINTENDENT—Or Superintendent of Nurses; registered New York; twelve years' experience in supervision, instructing, and as superintendent of nurses; B.S. Degree nursing education; wants a southern position. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

TECHNICIAN—X-ray; past eleven years chief x-ray technician large teaching hospital; for further details, please write Burneice Larson, Director, Medical Bureau, Palmolive Building, Chicago.

POSITIONS OPEN

ADMINISTRATION

ADMINISTRATOR—Graduate nurse with experience; 400-bed western county hospital; school of nursing program to be developed; salary open. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

ADMINISTRATORS—(a) Small hospital, eleemosynary, construction, equipping experience advantageous; Hawaii. (b) Large general hospital, medical man preferred; lay administrator elegible; south. MH 6-16, Medical Bureau (Burneice Larson, Director), Palmolive Building, Chicago.

ADMINISTRATORS—(a) Well-rated 90-bed southern hospital, location offering excellent recreational, educational facilities; salary above average. (b) Nurse; 75-bed Wisconsin hospital; salary open. (c) Growing Pennsylvania hospital, financially sound, well-equipped. (d) Purchasing agent; woman, with executive ability; purchase all hospital supplies except food; excellent middlewestern opportunity; salary open. M-92 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

NURSING—EXECUTIVE

DIRECTORS OF NURSES—Assistant. (a) Large mental institution; affiliated students; excellent educational program. (b) 150-bed hospital, eastern city; open September. (c) 375-bed Ohio hospital; salary $265. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

DIRECTORS OF NURSES—B.S. Degree. (a) 300-bed hospital, university city; $250, maintenance. (b) 250-bed hospital, near New York; ideal situation. (c) 150-bed hospital, midwestern city; graduate staff; $200, maintenance. (d) 85-bed Ohio hospital; college affiliation; $200, maintenance. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

DIRECTRESSES OF NURSES—(a) Large hospital, Chicago area; progressive training school; college background, experience desirable; salary dependent qualifications. (b) College graduate, mature, experienced; beautifully situated eastern hospital overlooking Long Island Sound; $225, maintenance. (c) Supervise all-graduate staff, 100-bed Ohio hospital near Cleveland; minimum salary $165, maintenance. (d) Some teaching, requiring degree, for growing Texas hospital; attractive location; salary open. (e) Assistant; college graduate, experienced rotating, assigning student nurses; large Ohio hospital; salary open. (f) Assistant; attractive Connecticut opportunity; salary open. (g) Assistant; Chicago suburban hospital, training school; attractive living facilities, good transportation; salary open. M-93 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

INSTRUCTOR—Clinical; one with degree and experienced in teaching and supervising preferable; training school of 40 to 50 students; 165-bed general hospital. Women's and Children's Hospital, Toledo, Ohio.

INSTRUCTOR IN NURSING EDUCATION—Appointment open for full time faculty member in field of nursing education, eastern university school of nursing; Master's Degree desirable; experience in university teaching preferred; $2500; east. MH6-2, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

INSTRUCTOR—Nursing arts; degree required; 226-bed general hospital; 100 students; salary dependent on qualifications. Apply Orange General Hospital, Orlando, Florida.

INSTRUCTORS — (a) Educational director; approved 150-bed general hospital; desirable location in large southwestern city. (b) Nursing arts; large general hospital, university affiliation; Saturday afternoon and Sunday off; four weeks vacation with pay; $180; California. (c) Nursing arts; general 250-bed hospital; 80 students in school; $150; south. (d) Nursing arts; 200 beds; $140, complete maintenance; metropolitan area, New York. (e) Science; will teach anatomy and physiology; Master's Degree desirable; appointment on faculty of college nursing education department; minimum salary, $150; west. (f) Science; will have responsibility for working out class schedules; 60 students in school of nursing; 150 beds; $150, maintenance; southeast. (g) Assistant instructor, pediatric nursing; appointment open on faculty of university school of nursing; salary open; midwest. MH6-3, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

WANT ADVERTISEMENTS

POSITIONS OPEN

NURSING—EXECUTIVE

INSTRUCTORS — (a) Psychiatric; southern affiliate school; attractive location, salary open. (b) Science; degree or partial college required; large well-rated Pennsylvania hospital; $150, full maintenance. (c) Practical arts; large hospital near Philadelphia; $135, full maintenance. (d) Science; pleasant eastern location, well-rated hospital paying attractive salaries. (e) Educational director; well-rated southeastern hospital; $200 monthly; desirable location. (f) Science; large southern hospital; salary open, will be above average. (g) Psychiatric; interesting middlewestern appointment in affiliate training school; $150 monthly. M-94 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

INSTRUCTORS—(a) Science, September opening; 225-beds, student body 100; weekends and two weeks vacation allowed; near Chicago. (b) Science, 300-beds, south; degree, experience; pleasant working conditions. (c) Nursing arts, one of the south's leading hospitals; southerner with good educational and personal qualifications; degree, experience. (d) Maryland, 125-beds, A.C.S. approved; accredited training school, 25 entering in September; relieves superintendent nurses during vacations; some college work. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

INSTRUCTORS — Clinical; experience. (a) 200-bed eastern hospital; $35, maintenance. (b) 175-bed university center, midwest; salary $145. (c) 200-bed Connecticut hospital. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

INSTRUCTORS—*Continued*

INSTRUCTORS—Nursing arts. (a) Chief; large sisters' hospital, Minnesota. (b) 175-bed hospital, eastern Pennsylvania. (c) 150-bed Ohio hospital; $150, maintenance. (d) 265-bed outstanding hospital, New Jersey. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

INSTRUCTORS — Science. (a) Chemistry, microbiology, anatomy and physiology; 250-bed hospital, Ohio; week-ends off duty; salary $160. (b) 250-bed church hospital, large city Missouri. (c) 175-bed hospital, suburb Philadelphia; educational advantages; $150, maintenance. (d) 200-bed North Carolina hospital. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

NURSE-EXECUTIVES — (a) Graduate nurse administrator will be considered to succeed male superintendent who is leaving for military service; approved 100-bed general hospital; excellent salary for qualified candidate; Wisconsin. (b) Small general hospital needs nurse superintendent; surgical experience desirable; $210; west. (c) Director of nursing service; general 300-bed hospital; $200, maintenance, including apartment; east. (d) Superintendent of nurses; will have no interference from any group; 130 students in school of nursing; 300 beds; $210, maintenance; Ohio. (e) Superintendent of nurses; new 100-bed hospital, to be opened in fall; proposed salary, $200; beautiful location, southeast. (f) Director of nurses; degree; 250-bed general hospital; $200, maintenance; midwest. (g) Superintendent of nurses; large state psychiatric hospital; will assist in establishing affiliated school for psychiatric training; $1800-$2000, maintenance; east. (h) Assistant dean, university school of nursing; administrative duties; will be responsible for planning instruction and class schedules; $175, maintenance with bonus; south. (i) Assistant director of nurses; duties largely general supervision, will maintain health service; opportunity for additional academic work in neighboring university; Pennsylvania. MH6-1, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

NURSE-EXECUTIVES—*Continued*

SUPERINTENDENTS OF NURSES—(a) Hospital of 120-beds, approved by A.C.S., daily average 95; new nurses home; cooperative staff; satisfactory salary. (b) 100 beds, North Carolina; accredited training school; wants fairly young nurse with good executive ability; salary depends on qualifications. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

SUPERINTENDENT OF NURSES—$225, northwest. Zinser Personnel Service, 1546 Marquette Building, Chicago.

NURSING—SUPERVISION

NURSE SUPERVISOR—Experienced as hospital executive; must be able to speak Spanish; two-year contract; $225, maintenance; transportation furnished; large industrial company; South America. MH6-10, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

SUPERVISOR—Obstetrical, one with ability to teach and supervise fifty-bed unit; postgraduate necessary. Women's and Children's Hospital, Toledo, Ohio.

SUPERVISOR—Operating room; well qualified, experienced, for responsible position, western university hospital; $225 monthly, interesting location. M-100 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

WANT ADVERTISEMENTS

POSITIONS OPEN

NURSING—SUPERVISION

SUPERVISORS — (a) Medical and surgical floor; medium-sized general hospital; $130, maintenance; midwest. (b) Medical-surgical unit, non-segregated; appointee will be permitted to take work at neighboring university if desired; $125, maintenance; Pennsylvania. (c) Obstetrical; appointee must have ability to handle experienced staff of 35 nurses in large unit; degree required; 48-hour week; every other Sunday off duty; $200; large general hospital, university affiliation; California. (d) Obstetrical; new general 130-bed hospital, to be opened in early fall; $140; east coast. (e) Operating room; university hospital with active surgical service; $225; west. (f) Operating room; busy department; no night call; four weeks vacation allowed; $140, maintenance; 350 beds; east. (g) Operating room; must be capable handling all types of surgery; 200 beds; $135, maintenance, increase promised; Gulf Coast. (h) Pediatric; post-graduate work required; $125, maintenance; 100 beds; Illinois. (i) Pediatric instructor and supervisor; large university hospital; $185 cash salary; resident privileges if desired; west. (j) Night; experienced in administrative work; $160, meals; New York. (k) Operating room, Hawaii. MH6-4, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

SUPERVISORS—(a) Night; $120, maintenance; middlewest. (b) Operating room; $135, maintenance; south. (c) Medical floor; $110, maintenance; east. Zinser Personnel Service, 1546 Marquette Building, Chicago.

SUPERVISORS—(a) Operating room; fully approved Connecticut hospital requiring post-graduate training, experience; $140, full maintenance. (b) Pediatric; well qualified; large New Jersey hospital, well-equipped department including new premature unit; salary dependent qualifications. (c) Clinical; well-located eastern hospital offering excellent working, living facilities; $115, full maintenance. (d) Obstetrical; post-graduate required; desirable Oregon location; $135, full maintenance. M-97 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

SUPERVISORS—Night; experienced. (a) 400-bed hospital, midwest; ideal situation, several assistants. (b) Pediatric; children's hospitals, midwest, east, west coast; $160. (c) Operating room; 175-bed eastern hospital; $160, maintenance. (d) Operating room; 150-bed Ohio hospital; new surgical suite; $165, maintenance. (e) Obstetrical; 200-bed hospital, central New York; $160. (f) 150-bed Wisconsin hospital; salary $135. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

SUPERVISORS—Surgical. (a) 250-beds, eastern location, July opening; good salary, including complete maintenance. (b) 125-beds, southwest; good living conditions and salary; very best qualifications. (c) Obstetrical, excellent basic training, post-graduate course and experience; midwest; salary open. (d) medical-surgical, 50-beds, western location; $130, full maintenance. (e) Pediatric; post-graduate course, teaching ability; salary open. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

NURSING—GENERAL

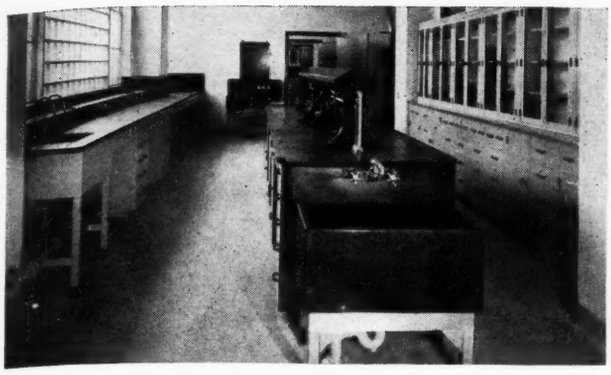
GENERAL DUTY NURSES—(a) Arizona; general hospital, heavy surgical census; $135, maintenance, good working, living conditions; transportation refunded after eight months' employment. (b) California; well-rated hospital, attractive southern residential city; $140 monthly, periodic increases. M-98 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

GENERAL DUTY NURSES—(a) $135, maintenance; southwest. (b) $1620; east. (c) $110; middlewest resort town. Zinser Personnel Service, 1546 Marquette Building, Chicago.

GENERAL DUTY NURSES—(a) Staff nurse for new government hospital, opening for defense workers; salary range, $140-$170, dependent on qualifications; northwest. (b) General duty nurse; 8-hour day, 6-day week; small general hospital; $120, maintenance; Michigan. (c) General duty nurse; approved contagious hospital; $117.50, maintenance; New England. MH6-9, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

INDUSTRIAL NURSES—(a) Large ordnance plant needs industrial nurse; duties consist of general industrial hygiene, first aid, hospital duty, pre-employment physical examination; 8-hour day, five consecutive days duty weekly; uniforms furnished and laundered; dormitory accommodations; salary dependent upon qualifications; south. (b) Graduate nurse needed in company hospital of large lumber company; $150, complete maintenance; California. MH6-6, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

PUBLIC HEALTH NURSES—(a) Health educator; previous experience in teaching or counseling desired; salary open; Alaska. (b) Public health nurse, to assist in health pro-



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JARVIS & JARVIS, INC.
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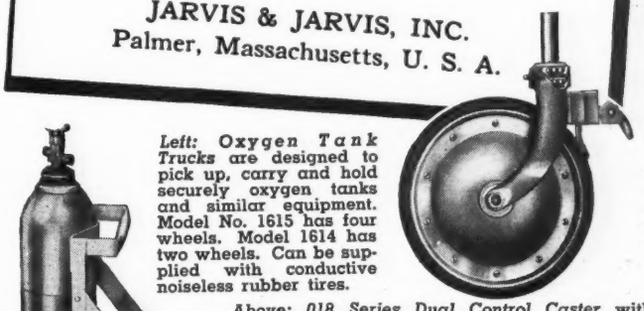
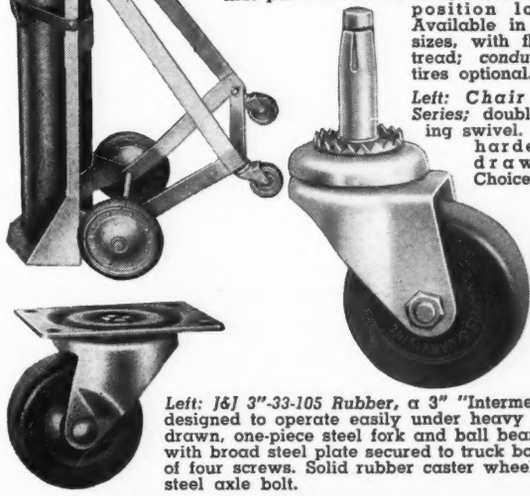


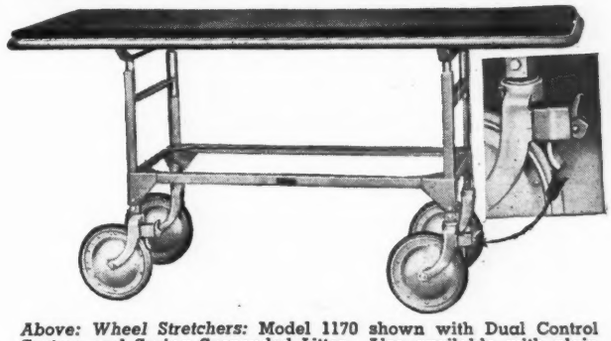
Left: Oxygen Tank *Trucks* are designed to pick up, carry and hold securely oxygen tanks and similar equipment. Model No. 1615 has four wheels. Model 1614 has two wheels. Can be supplied with conductive noiseless rubber tires.

Above: 018 Series Dual Control Caster with double ball bearing swivel, recommended for use on stretchers. Movement of foot trigger to first position locks swivel; movement to second position locks wheel. Available in 8" and 10" sizes, with flat or round tread; *conductive* rubber tires optional.



Left: Chair Caster, 151 Series; double ball bearing swivel. All parts of hardened deep drawing steel. Choice of 1⅝ in., 2 or 3 in. wheel sizes. Wheels either of all hard rubber, or hard rubber core and soft rubber tread. Conductive rubber tires optional.

Left: J&J 3"-33-105 Rubber, a 3" "Intermediate" caster designed to operate easily under heavy loads. Deep-drawn, one-piece steel fork and ball bearing raceway with broad steel plate secured to truck body by means of four screws. Solid rubber caster wheel mounted on steel axle bolt.



Above: Wheel Stretchers: Model 1170 shown with Dual Control Casters and Spring Suspended Litter. Also available with plain casters, Fixed Solid Litter, Elevating Side Rails, etc.; Noiseless Pads and Tires *conductive* or non-conductive rubber as required.

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NURSING—GENERAL

PUBLIC HEALTH NURSES—*Continued*

gram for employees of large organization; minimum salary, $155, with periodic bonuses; midwest. (c) Public health supervisor for large city health department; must meet requirements of N.O.P.H.N. for educational supervisor; will be in charge of teaching center for induction of new staff nurses, and field supervisor of twenty nurses; $2500, with annual increases for merit; large midwestern industrial city. MH6-7, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

SCHOOL NURSE—Resident infirmary nurse; boys' preparatory school with enrollment of 250 students, grammar and high school age; well-equipped dispensary, x-ray machine, and infirmary of 18 beds with isolation cottage; appointee employed on ten months' basis with two months' summer vacation; salary open; east. MH6-8, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

SURGICAL NURSES—(a) Opening in small industrial hospital, located in mining district; $200, complete maintenance; west. (b) Scrub nurse; 200-bed general hospital, university affiliation; 8-hour duty; $135, maintenance; California. MH6-5, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

ANESTHESIA

ANESTHETISTS—(a) Experienced anesthetist needed in general 100-bed hospital; $200, maintenance; Michigan. (b) Vacancy in 125-bed general hospital; two anesthetists employed; average 150-180 anesthetics per month; $165, maintenance; Texas. (c) Full-time anesthetist needed in general hospital; $150, maintenance; non-resident privileges if desired; California. (d) Well-known clinic has opening for full-time anesthetist; $150, maintenance; midwest. (e) General hospital, Hawaii. MH6-11, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

ANESTHETISTS—*Continued*

ANESTHETISTS—(a) 6 anesthetists employed; 350-bed midwestern hospital. (b) 200-bed hospital, New York City; salary $200. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

ANESTHETISTS—(a) 200-bed California hospital needs two; $250 per month, including laundry. (b) Third assistant instructor, large university hospital; training and teaching interest more important than experience; splendid opportunity for experience in administering wide variety of surgical anesthetics. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

ANESTHETISTS—(a) Well-rated middlewestern hospital; $205 monthly; location offers many advantages. (b) Fully approved Ohio hospital; $175, full maintenance. M-95 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

FOOD SERVICE

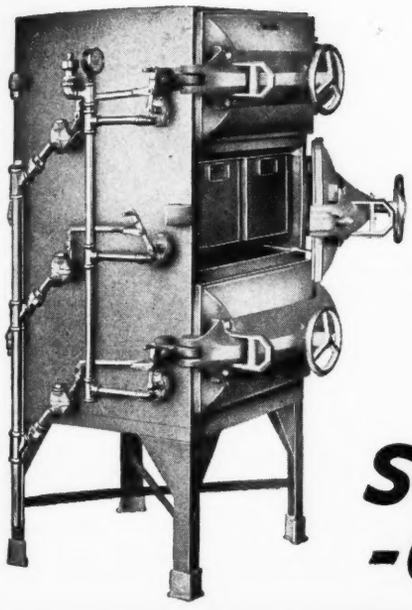
DIETITIAN—Assistant, one with experience preferable but not necessary; 165-bed general hospital. Women's and Children's Hospital, Toledo, Ohio.

DIETITIAN—Therapeutic; will be in charge of diets and also will teach student nurses; some administrative work; salary open; 320-bed Ohio hospital. NZ 202, The Modern Hospital, 919 N. Michigan Avenue, Chicago.

DIETITIANS—(a) Administrative dietitian; one of the leading hospitals; metropolitan area; New York City. (b) Chief dietitian, fairly large hospital; suburban location, eastern city; $250, maintenance. (c) Therapeutic dietitian; 400-bed hospital; Pacific coast. (d) Chief dietitian; one of the leading hospitals in Chicago area; minimum, $200, including partial maintenance. (e) Dietitian to take charge, completely equipped hospital, modern in every detail; serving low income farm workers in rich agricultural section; $150, maintenance; south. (f) Chief dietitian; well equipped new hospital serving shipyard workers; interesting connection; west. (g) Dietitian who has had experience in commercial cafeterias; large manufacturing company; east. (h) Chief and assistant dietitians; new hospital nearing completion; beautiful location; salaries $175 and $125 respectively, including maintenance. MH6-13, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

DIETITIANS — (a) Administrative; 300-bed hospital, eastern industrial center; $250, maintenance. (b) Therapeutic; 200-bed hospitals, Ohio, New York, Maryland, Michigan, Illinois. (c) 65-bed midwestern hospital; $135, maintenance. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

DIETITIANS — (a) Chief; complete charge well-staffed dietary department, 350-bed eastern hospital; $250, full maintenance. (b) Chief; 250-bed middlewestern hospital, well-rated, with cooperative staff; $175 monthly. M-96 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.



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CAN HELP to EASE FOOD RATIONING

Rationing restrictions on food service establishments necessitate the use of more fresh vegetables and other foods, to replace canned and processed items now severely curtailed.

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The fortunate possessor of a Steam-Chef can now use this convenient unit to better advantage than ever, to prepare these fresh foods. Continuous cooking in any desired quantities, without water, conserves soluble vitamins and other vital food elements, (thus assuring high nutritive values) and retaining natural flavors.

to CAN fruits & vegetables

You can also use this convenient steamer to ***can your own*** fruits and vegetables. Simply put your glass jars in your Steam-Chef and follow, in general, the usual range-top cold pack method. Cooking time required may be slightly less than with the ordinary cold pack process, depending on temperature and pressure of steam.

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FOOD SERVICE

DIETITIANS—(a) $185; northwest. (b) $135, maintenance; east. Zinser Personnel Service, 1546 Marquette Building, Chicago.

DIETITIANS—(a) 240-bed Michigan hospital, two vacancies, $178 and $150, room out; cooperative staff; cafeteria service for employees. (b) 120-beds, Arkansas; $120, maintenance. (c) Attractive hospital, midwest; $150, maintenance. (d) 90-beds; Maryland; $100, maintenance. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

TECHNICIANS

PHYSICAL THERAPISTS—(a) Physical therapy technician; crippled children's units; Hawaii. (b) Instructor and coordinator of physio-therapy course; large teaching hospital. (c) Physical therapy technician; modern well equipped curative workshops for the rehabilitation of injured workmen; large industrial company. MH6-14, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

TECHNICIANS—(a) Laboratory—busy defense area, three employed; work under Pathologist; must be qualified in all procedures. (b) Attractive Tennessee city, 125-bed hospital; three full-time technicians; salary open; room, board, laundry included. (c) 100-beds; to relieve in x-ray; salary open—will be good. (d) Laboratory-x-ray, 65-beds, South Carolina; will meet prevailing salaries. (e) 150-beds,

TECHNICIANS—*Continued*

Missouri, attractive town; $140, full maintenance. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

TECHNICIANS—(a) Laboratory; $135, maintenance; California. (b) Laboratory and x-ray; $200; ordnance plant; southwest. (c) X-ray; $125, maintenance; middlewest. Zinser Personnel Service, 1546 Marquette Building, Chicago.

TECHNICIANS—(a) Laboratory; 150-bed Indiana hospital; salary $175. (b) X-ray, 200-bed Nebraska hospital; $125, maintenance. (c) Laboratory, x-ray; 100-bed West Virginia hospital; $175, maintenance. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

TECHNICIANS—(a) X-ray and laboratory technician; industrial hospital; northern California; $183.97, including maintenance. (b) X-ray technician; minimum, $175; fairly large hospital; university medical center; east. (c) X-ray and laboratory technician; fully approved small hospital; beautiful location; Alaska. (d) Technician qualified in x-ray and laboratory work; 125-bed hospital; fully approved; $175, maintenance; town of 20,000, southeast. (e) X-ray and laboratory technician; beautifully equipped department; new hospital, 400 beds, owned and operated by one of the country's most important industrial companies; midwest. (f) Two laboratory technicians; fully approved institution; laboratory handles large volume of all types of laboratory work; full-time pathologist; eight technical assistants; ideal set-up; blood bank under government auspices; west. MH6-15, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

MISCELLANEOUS

LIBRARIANS—Record. (a) Large Tennessee hospital, $125, room out. (b) 85-beds, approved hospital wants registered librarian; $120, board and laundry; midwest location. (c) Two assistants for Michigan hospital due to expansion program; either may become head of department. (c) 100-beds, Ohio; $125, room out. (d) Surgical secretary, large Washington hospital; eight hour duty; $100, meals. North's Hospital Registry, 406 Republic Building, Louisville, Kentucky.

LIBRARIANS—Record. (a) Registered record librarian needed by general 300-bed hospital; will have charge of record room; $150; California. (b) New 100-bed hospital, to be opened in fall, requires experienced record librarian; proposed salary, $125-150, live in; southeast. MH6-12, Medical Bureau (Burneice Larson, Director) Palmolive Building, Chicago.

LIBRARIANS—Record; large and small hospitals; Connecticut, New York, Ohio, Illinois, Wyoming; salaries $140-$150, maintenance. Interstate Hospital and Personnel Bureau, 332 Bulkley Building, Cleveland, Ohio.

MISCELLANEOUS—(a) Clinic nurse; well-established southwestern group of specialists; salary open, will be attractive. (b) Industrial nurse; middlewestern defense plant; salary open. (c) Infirmary nurse; unusually interesting appointment, eastern boys' preparatory school; excellent working facilities; salary open. (d) Out-patient nurse; attractively located southern children's hospital; salary open. (e) Physiotherapist; fully approved Ohio hospital; salary open. (f) Record librarian, registered; pleasant community hospital near New York City; salary open. (g) School nurse; training or experience public school work desirable; $180 monthly; Illinois. (h) Surgical nurse; Arizona industrial hospital; $150, full maintenance. M-99 Aznoe's-Woodward Medical Personnel Bureau, 30 N. Michigan, Chicago.

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Kentile is cleaned with the very least amount of trouble and manpower. It doesn't dust, doesn't "hold" dirt, is virtually stainproof, is cleaned by simple mild soap-water mopping.

Kentile is so wear-resistant that hallways laid 15 years ago are still as perfect as new.

Kentile bears 1000 lb. rolling loads without denting or tracking, isn't marked by scuffing.

Kentile is resilient — comfortable underfoot and noise-deadening.

Kentile is moisture-proof and can even be laid on concrete that's directly over earth.

Kentile isn't slippery even when wet.

Kentile is available, where necessary, in a Greaseproof tile that isn't stained by any animal, vegetable or mineral oil, fat or grease.

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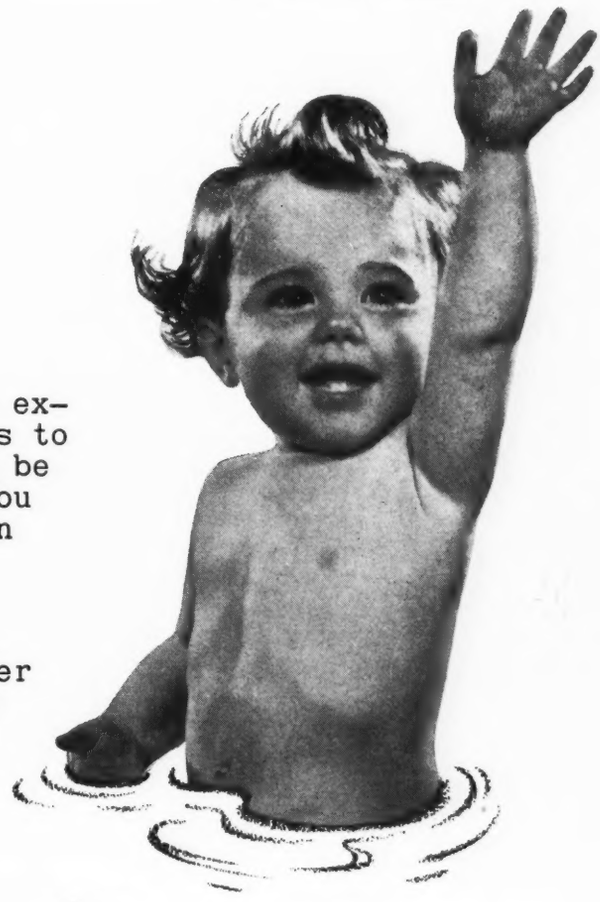
DAVID E. KENNEDY, Inc., 56 SECOND AVE., BROOKLYN, N. Y.

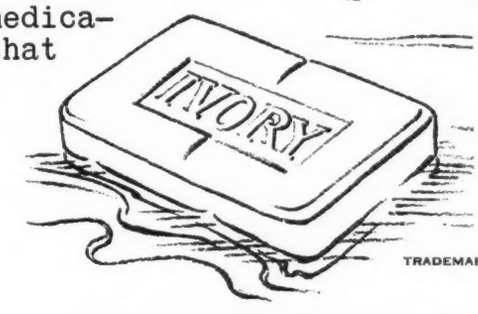
How mild is MILD?



It goes without saying that you expect a soap you use for patients to be mild. But soap mildness can be a matter of opinion. For, as you know, not all soaps are alike on this score.

Ivory Soap's mildness is not a matter of opinion...it's a matter of fact! By actual test, Ivory Soap is milder than 10 leading toilet soaps. Milder than 42 out of 44 imported castiles bought at random in 6 cities.

Ivory is free from dye, medication, or strong perfume that might be irritating to a patient's skin. It's a fine, pure soap you can depend upon for thorough, gentle cleansing.



TRADEMARK REG. U. S. PAT. OFF.

Procter & Gamble

IVORY SOAP

99 44/100% PURE . . . IT FLOATS

Pure, mild, rich lathering Ivory Soap is available for hospital use in a choice of six convenient individual service sizes. Cakes weigh from ½ ounce to 3 ounces, and may be had either wrapped or unwrapped. You may buy the new Velvet-Suds Ivory, too, in the familiar medium and large household sizes for general institutional use.

AFTER HOURS

More on War "Surplus"

SOME MONTHS ago this space was given over to a discussion of the disposal of medical stores, including hospital equipment and supplies, now being produced in vast quantities for the armed forces. An editorial in the same issue made the suggestion that at the end of the war the proper authority turn this material over to the American and International Red Cross and to the group headed by Herbert H. Lehman, so that hospital and medical aid may go along with food and clothing in the rehabilitation of the war ravaged nations of Europe and Asia.

At that time we pointed out not only that these stores would serve an important humanitarian cause but that such disposition would prevent their return to the domestic market as "war surplus" in competition, at murderously low prices, with the manufacturers who had produced them.

Our suggestions met with an immediate response, favorable to the main idea yet with some feeling that we were looking too far into the future at a time when victory was still to be won. Recently, in a paper read before the National Conference on Planning for War and Postwar Medical Services, Col. Charles F. Shook, M.C.U.S.A., who has explored this problem at some length, made it clear that due regard for postwar eventualities is anything but premature.

Colonel Shook is in an excellent position to grasp the whole subject of medical stores and to understand the needs of today and tomorrow as well as the implications of any "dumping" of war matériel on the postwar economy. His conclusions, therefore, must carry considerable weight. His suggestions are (1) that by an act of Congress or by a Presidential ruling under the War Powers Act manufacturers who filled government contracts be permitted to repurchase surplus materials remaining in the hands of the government after the cessation of hostilities; (2) that a reasonable store of nondeteriorating supplies and equipment be maintained against future emergency; (3) that a procurement planning division be made a part of any rehabilitation program to determine needs and sources; (4) that price protection legislation be enacted; (5) that postwar study be made now on the part of manufacturers; (6) that a sufficient time interval (on equipment and nondeteriorating supplies) be allowed before declaration of surpluses for proper steps to be taken to alleviate the effect on industry.

Colonel Shook also suggests other outlets for surplus, such as Veterans' hospitals, the Red Cross and soldiers' rehabilitation agencies. While it is Army policy that such a statement as this has no official status, there is no doubt that so logical a pronouncement from so well-informed an individual will have great influence among those upon whom responsibility will rest. There seems good reason now to assume that no deluge of distress and often deteriorated merchandise will be offered in competition with its original producers, such as reached the market often through none too reputable channels after the peace of 1918.

—THE PUBLISHER

A fresh diaper every time...

—and no laundry problems!

• An overworked stork . . . the cloth diaper shortage . . . depletion of personnel and inadequate laundry facilities are four major reasons why hospitals are putting Chux, the completely disposable diapers, high up on the order list. The water-repellent backing on Chux helps protect linen. Fewer linen changes and less frequent washings are required.

Small size (for babies to 12 lbs.)—9¼" x 14", packed 600 in a case. Large size—13¼" x 19", 400 in a case.

HOSPITAL DIVISION

Johnson & Johnson

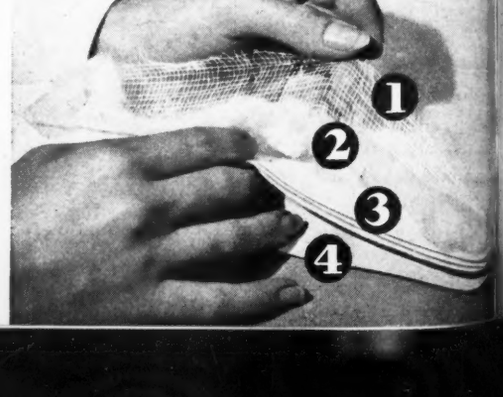
NEW BRUNSWICK, N. J. CHICAGO, ILL.

ARMY E NAVY

CHUX

Four Protective Layers

1. Absorbent gauze covering.
2. Layer of soft, filmated cotton.
3. Absorbent cellulose center.
4. Water-repellent paper back.



What's New for Hospitals

JUNE 1943 SUPPLEMENT TO THE MODERN HOSPITAL AND THE HOSPITAL YEARBOOK

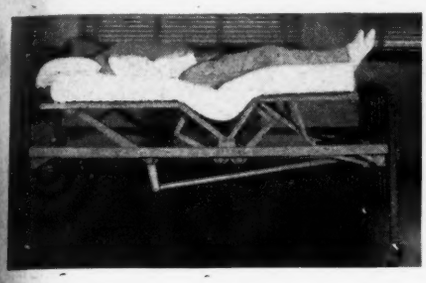
THIS supplement presents information on significant hospital products for the use of administrators, department heads and medical personnel. Only items of definite application in hospitals are described.

THE MODERN HOSPITAL PUBLISHING CO., INC.
919 North Michigan, Chicago, Ill.

Seven-In-One Bed

The new Simmons L-1204 Deckert Bottom for hospital beds offers seven advantages with a simple, uncomplicated mechanism which can be easily operated by any physician, nurse or other hospital attendant. Designed by Mr. C. A. Deckert, nurse, and manufactured by Simmons Company, the bed combines several new features with standard Gatch, Fowler, Trendelenburg and other positions. A considerable amount of experimental work at Stanford University, Cornell Medical Center and other hospitals has been carried on to bring out all of the advantages of the bed.

Especially designed to facilitate the use of bed and douche pans with more ease and comfort for the patient as well as for the attendant, the bed has four sections which permit of many positions. It



is so designed that when the waist line of the patient is directly above the first break in the spring bottom, the use of bedpans is greatly simplified and it is possible for one nurse easily to serve a helpless patient. With the bed in the position shown in the illustration, the bedpan can be placed under the patient without moving or disturbing him, and without strain on the nurse or other attendant.

In addition the bed provides more comfortable, more effective enema position, more comfort and increased security in Trendelenburg, Fowler and cardiac positions, increased therapeutic efficiency for the patient in these positions, and it can be used as an emergency operating table. Position for spinal curvature is also possible. The bed brings several features to a standard hospital bed at a reasonable cost.

The appearance and construction of the bed are similar to a standard, mechanically-operated posture bottom bed with the exception that this is equipped with an additional crank-handle and shaft centrally located at the foot of the bed. Of standard width, the bottom is six inches longer than standard to permit the head and foot sections to operate properly. This also permits the accommodation of patients taller than the average. **(Key No. 1656)**

Simmons Co., Dept. MH, Merchandise Mart, Chicago, Ill.

Surgical Instrument Cleaner

A chemical formula in powder form, Haemo-Sol has been developed by Meinecke and Company for cleaning surgical instruments as well as rubber and glass that are clotted with blood and tissue or clouded by mucus or solutions. Haemo-Sol is a blood solvent and also removes tissue from locks and serrations of surgical instruments without scrubbing.

One ounce of Haemo-Sol in each gallon of water at about 125 degrees cleans instruments placed in the solution. The length of time required for cleaning depends upon whether the instruments have just been used or if they have been allowed to dry. The solution may be re-used as long as it is not too dirty. Haemo-Sol keeps instruments in their original bright condition and has no harmful effect on the hands. **(Key No. 1658)**

Meinecke & Co., Dept. MH, 225 Varick St., New York, N. Y.

Mobile Electron Microscope

A new electron miscroscope that is mobile, small and operates on ordinary house current was recently announced by the General Electric Electronics Laboratory. The development of this device makes it possible for small laboratories to use this type of instrument which is capable of producing images 10,000 times the size of the subject. Further enlargement is possible when desired. Designed by Drs. C. H. Bachman and Simon Ramo, the device uses the relatively small electron waves instead of light waves which permits of the study of smaller objects.

Standing 52 inches high, the new microscope requires about 2 by 3 feet of floor space. The cabinet includes the simple power supply, the mechanical vacuum pump and an air-cooled, oil-diffiusion high vacuum pump. It is mounted on casters and requires no special facilities for operating the

instrument. All controls are at the operator's fingertips and the unit is designed for the convenience of the operator. **(Key No. 1660)**

General Electric Co., Dept. MH, Schenectady, N. Y.

Urine pH Comparator

Similar to the sulfa and urea nitrogen comparators, the Taylor Urine pH Comparator consists of a base and slide, both molded from plastic. The slide contains nine standards representing pH values and the base contains two vials of Benzo Red indicator with 0.5 cc. pipettes and five 5 cc. test tubes.

A determination is made simply by filling three of the test tubes with a sample, placing them in the base and adding 0.5 cc. of indicator to the middle one. The sample is compared with the standards by moving the slide until a color match is obtained and the pH is read on the slide. **(Key No. 1657)**

W. A. Taylor & Co., Dept. MH, 7301 York Rd., Baltimore, Md.

Address manufacturers for further information and prices—or use Readers' Service blank on page 180

Wood Furniture Line

Because of the lack of steel, the Hard Manufacturing Company has developed a full line of hospital furniture in wood. Designed, tested and perfected to replace steel, the new line is made of high quality hardwood, kiln dried. All items are completely finished in a sealing coat, a graining base coat, a wood grain and a varnish coat handrubbed.

The overbed table and bedside table have a new top developed by this manufacturer and known as Hardalyte. It is designed to be fireproof and to resist chemicals and severe treatment. Full furniture equipment for patients' and nurses' rooms has been brought out in the new wood line. However, steel beds for patients, with gatch springs or link springs, and metal cribs and bassinets are still available. A double deck bunk and a litter have also been made in the wood line. **(Key No. 1654)**

Hard Mfg. Co., Dept. MH, 117 Tonawanda St., Buffalo, N. Y.

Synthetic Sheeting

Uscoplast is a waterproof sheeting made without rubber and consisting of a plastic material on a heavy muslin base. It can be washed, ironed, sterilized and subjected to severe hospital use. It can also be cleaned with a damp cloth. The finish is not affected by olive oil, bloodstain, ammonia, sodium bicarbonate or metaphen. Uscoplast Sheeting is available in either single coated or double coated types. **(Key No. 1659)**

U. S. Hospital Supply Co., Dept. MH, 223 S. 6th St., Minneapolis, Minn.

Air-Conditioned Incubator

The Davidson Incubator has been completely redesigned as to structual features, greatly simplifying its operation. Two new features include an alarm light and buzzer in case the air vent is closed or the oxygen flow is disturbed and an ultraviolet ray bactericidal light through which the incoming air flows. Hand ports for nursing and medical care have rubber cuffs to prevent loss of oxygen, temperature changes or drafts. No interruption or change in atmospheric conditions need be experienced while the incubator is in use.

The operating panel has two switches, one to start the motor and the other for heat. Both are switched on when the incubator is in service. A dial or knob in the center controls the temperature and a door at the bottom gives access to the ice compartment and humidifying chamber. In addition to temperature and humidity controls, the incubator provides for oxygen treatment when needed. The unit is fully automatic and simple to operate. **(Key No. 1663)**

Stanley Supply Co., Dept. MH, 121 E. 24th St., New York, N. Y.

Food Dispensing Truck

A food dispensing truck designed to carry hot and cold beverages and foods has been developed of hardwood and plastic sheeting. Available in specified arrangement of food utensils, electric

heating and cooling equipment is supplied to meet requirements.

The storage compartment with sliding doors measures 12 by 26 by 52 inches. The truck has ball-bearing casters, is 63 inches high, 30 inches wide and 62 inches long. **(Key No. 1666)**

Folding Metal Products Co., Dept. MH, Fremont, Ohio.

Lightweight Stretcher-Kot

The improved Stretcher-Kot is now being made of all wood and has practically no critical materials. Easy to handle and light in weight, this product has a special wood frame into which a fabric center is laced. The four wood legs are rigidly bolted to the rail and both ends

of the Stretcher-Kot are specially processed to retain the right amount of spring. These processed ends prevent any sagging even after the Kot has had repeated use. The continuous rail allows the unit to be picked up from any position when occupied. Finished in natural wood, the Kot is protected with varnish.

The Stretcher-Kot can be used in an ambulance, station wagon or truck for transporting patients and if necessary they can be left on the Kot after treatment. The No. 6 cotton duck fabric can be easily unfastened and quickly replaced. The Kot weighs less than 12 pounds and is 78 inches long, 25 inches wide at the head end, and 8 inches high. The frame is made of specially selected ash and the Kots are designed to be hung on the wall or stacked out of the way when not in use. **(Key No. 1591)**

Richard H. Keech, Distributor, Dept. MH, P.O. Box 23, Madison, N. J.

Plastic Name Plates

To replace bronze and brass plates and letters, a line of white core plastic name plates, porcelain on steel plates and reflecto letters has been designed. Available in any size with several styles of letters, these plates are indestructible and can be cleaned with a damp cloth. **(Key No. 1665)**

George Steere & Sons, Dept. MH, 107 W. Van Buren St., Chicago, Ill.

Sweeping Preparation

A new type of sweeping compound has been developed for use on all types of resilient flooring. Known as "No Spot," the compound contains no oil, water or sand and does not spot, stain or scratch the surface. It absorbs dry dust, grit and dirt and was designed for use on fine wood floors, asphalt tile, rubber tile, cork tile, linoleum, mastic, terrazzo and composition floors of all kinds. **(Key No. 1664)**

Frank Miller & Sons, Dept. MH, 2252 W. 58th St., Chicago, Ill.

Address manufacturers for further information and prices—or use Readers' Service blank on page 180

PHARMACEUTICALS

Sulfamone

A stabilized aqueous solution of sodium sulfathiazole and dl-desoxyephedrine, Sulfamone is intended for topical application to the nasal mucosa in infections secondary to the common cold. It contains 2.5 per cent sodium sulfathiazole sesquihydrate, 0.125 per cent dl-desoxyephedrine hydrochloride and 2.0 per cent sodium sulfite, anhydrous. The product is available in one ounce bottles with dropper and in one pint bottles. **(Key No. 1671)**

Parke, Davis & Co., Dept. MH, Detroit, Mich.

Pyrinate A-200

An ointment containing pyrethrum, obtained from the painted daisy, has been developed for use in eliminating body lice. Research in the use of this ointment has been conducted by Dr. Walter K. Angevine of Washington, D. C. Dr. A. L. Omohundro, technical director of the research and manufacturing laboratories of McKesson and Robbins, collaborated in the research on this product which is now being made available for general use.

The ointment preparation has proved effective in the eradication of these parasites and their eggs or nits, also of chiggers and dog fleas, without allergic manifestations. It is easy to use and is spread on the body and left for fifteen minutes and then washed off with soap and water. It is nontoxic. **(Key No. 1593)**

McKesson & Robbins, Inc., Dept. MH, Bridgeport, Conn.

Surplex Ferrous

A syrup containing the vitamin B complex fortified by the addition of certain pure crystalline vitamins and also supplying iron in the form of ferrous sulfate, Surplex Ferrous is intended for use as a hematinic and nutritional supplement in patients with secondary anemia who also show signs of inadequate intake of the vitamin B complex. Three teaspoonfuls of Surplex Ferrous contain ferrous sulfate 9 grains, thiamine 3 mg., riboflavin 3 mg., nicotinamide 18 mg., pyridoxine 0.375 mg. and rice bran concentrate syrup, containing pantothenic acid and other B complex factors, q. s. Surplex Ferrous is supplied in 12 fluid ounce and one gallon bottles. **(Key No. 1329)**

Abbott Laboratories, Dept. MH, North Chicago, Ill.

RECENT CATALOGS AND BOOKLETS

• **"Syringes are needed at the front. Make ours last!"** This is the heading of a poster on the care of hypodermic syringes which should prove valuable in every hospital. Complete instructions for the care and cleaning of syringes are given in simple terms in outline form and typical syringe breaks and their causes are illustrated. This is part of the conservation program of Becton-Dickinson & Co., Rutherford, N. J., in an effort to cut down breakage and rejection of syringes. **(Key No. 1661)**

• A clinical reference manual on **"Sex and Gonadotropic Hormones"** has been prepared by Roche-Organon, Inc., Nutley, N. J. Disorders of the female and of the male are discussed with details of recognized therapy. The booklet is attractively prepared and should prove helpful and informative. **(Key No. 1672)**

• **"Films on Surgery"** is the title of a booklet which lists the films in the library of Davis & Geck, Inc., 57 Willoughby St., Brooklyn, N. Y. These cover all branches of surgery and are available, without charge, for group showings to hospitals, medical schools and accredited medical and surgical societies. **(Key No. 1677)**

• Considerable information on the history, preparation, formulas and use of cosmetics together with a list of ingredients which may cause skin sensitization is included in the revised edition of **"History and Scientific Formulation of Cosmetic Preparations"** published by Richard Hudnut, 113 W. 18th St., New York, N. Y. Much of this material has not previously been available and should prove helpful to dermatologists and others responsible for the care and treatment of skin conditions. **(Key No. 1678)**

• The Fifth Edition of **"Vitamin Products for Prescription Use,"** issued by Eli Lilly & Co., Indianapolis, Ind., is an informative booklet. Thumb indexed for ease in reference use, the booklet lists the various vitamin products with therapeutic indications for each and includes a chart giving vitamin value of foods as well as a very complete bibliography of informative papers on vitamins. **(Key No. 1632)**

• An attractive booklet giving the history and uses of **Carotene,** source of vitamin A, with information on its importance in nutrition, has been prepared by S.M.A. Corp., 8100 McCormick Blvd., Chicago. **(Key No. 1682)**

• **"Keeping Fit in Wartime,"** the importance of vitamin C in the nutrition program, is the title of a booklet issued by the Florida Citrus Commission, Lakeland, Fla. The booklet contains information which should be of interest to the dietitian as well as to the patient and quantities will be sent if desired for distribution to patients. **(Key No. 1688)**

• **Wyeth's Hemo-Guide** is a chart designed to aid in the differential diagnosis of anemia by facilitating the interpretation of laboratory data. In handy card form for quick reference, the Hemo-Guide has been prepared by John Wyeth & Brother, 1600 Arch St., Philadelphia, Pa. **(Key No. 1686)**

• An illustrated educational poster to help avert possible loss through careless dispensing and handling of adhesive plaster has been prepared by Johnson & Johnson, Hospital Div., New Brunswick, N. J. Headed, **"Perishable, Handle With Care,"** the poster gives timely suggestions for the care of adhesive plaster. Copies are available for posting in storerooms, central supply and other departments using or dispensing this product. **(Key No. 1685)**

• The circular blood bank refrigerator with revolving shelves and the Arctic Trunk for freezing and storing plasma are illustrated and described in a folder on **"Blood and Plasma Refrigerators"** just published by Jewett Refrigerator Co., Inc., Buffalo, N. Y. **(Key No. 1676)**

• Armour and Company, Chicago, has prepared a folder illustrating and describing **"Ten Delicious Sandwiches"** prepared by Jean Lesparre, consulting chef in charge of their Experimental Sausage Kitchen. All made with Armour's Star liver sausage, the sandwiches offer variety and interest. **(Key No. 1610)**

• Leaflets describing the uses of **Rutland Patching Plaster** and **Rutland Concrete Patcher** have been prepared by Rutland Fire Clay Co., Rutland, Vt. **(Key No. 1683)**

• A comprehensive study of **"Stainless Steels, an Elementary Discussion,"** is presented in a 32 page booklet prepared by Allegheny Ludlum Steel Corp., Brackenridge, Pa. A general description of the product, corrosion resistance and fabrication are the subjects covered. **(Key No. 1631)**

• A folder describing **"Han-San"** liquid toilet soap and its uses has been issued by Finnell System, Inc., Elkhart, Ind. **(Key No. 1684)**

TO HELP YOU get information quickly on new products we have provided the convenient Readers' Service Form below. Just check the items of interest to you, tear out the coupon and place in an envelope addressed to:

Readers' Service Department
The Modern Hospital Publishing Co., Inc.
919 North Michigan Avenue
Chicago, Illinois

Send Me, through the manufacturers, further information on the following items I have checked.

- ☐ 1329 Surplex Ferrous
- ☐ 1591 Lightweight Stretcher-Kot
- ☐ 1593 Pyrinate A-200
- ☐ 1610 "Ten Delicious Sandwiches"
- ☐ 1631 "Stainless Steels"
- ☐ 1632 "Vitamin Products for Prescription Use"
- ☐ 1654 Wood Furniture Line
- ☐ 1656 Seven-In-One Bed
- ☐ 1657 Urine pH Comparator
- ☐ 1658 Surgical Instrument Cleaner
- ☐ 1659 Synthetic Sheeting
- ☐ 1660 Mobile Electron Microscope
- ☐ 1661 "Syringes are needed at the front"
- ☐ 1663 Air-Conditioned Incubator
- ☐ 1664 Sweeping Preparation
- ☐ 1665 Plastic Name Plates
- ☐ 1666 Food Dispensing Truck
- ☐ 1671 Sulfamone
- ☐ 1672 "Sex and Gonadotropic Hormones"
- ☐ 1676 "Blood and Plasma Refrigerators"
- ☐ 1677 "Films on Surgery"
- 1678 "History and Scientific Formulation of Cosmetic Preparations"
- ☐ 1682 Carotene
- ☐ 1683 Ruiland Patching Plaster
- ☐ 1684 "Han-Sen"
- ☐ 1685 "Perishable, Handle With Care"
- ☐ 1686 Wyeth's Hemo-Guide
- ☐ 1688 "Keeping Fit in Wartime"

- ☐ 1044 Nursing Supplies
- ☐ 1156 Acoustics
- ☐ 1158 Flooring
- ☐ 1363 Cooking
- ☐ 1369 Burns
- ☐ 1680 Deodorant
- ☐ 1689 Burn Therapy
- ☐ 1692 Maintenance
- ☐ 1693 Mattress

I would also like to have information on the following products

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NAME _____ TITLE _____

HOSPITAL _____

STREET _____

CITY _____ STATE _____

DO YOU HAVE THESE IN YOUR FILES?

Write the manufacturer direct—or use the Readers' Service Bank on this page.

Mattress. Complete information on Taylor-made Morning Glory and Sanidown Mattresses, also mattress protectors, pillows, box springs, sofas and chairs. Taylor Bedding Mfg. Co., Taylor, Tex. **(Key No. 1693)**

Burn Therapy. "Foille for Burns and Wounds," an illustrated booklet on the use and effect of this burn treatment, reprint of "A Comparative Study of Local Burn Treatments" by Captain Joseph E. Hamilton, M. C., and folder of Questions and Answers regarding Foille. Carbisulphoil Co., 3114 Swiss Ave., Dallas, Tex. **(Key No. 1689)**

Deodorant. Folder on "Staph-ene," disinfectant, germicide, deodorant and cleanser that leaves no odor. Vestal Chemical Laboratories, Inc., 4963 Manchester Ave., St. Louis, Mo. **(Key No. 1680)**

Cooking. "Getting the Most From Steam Cooking." 36 page booklet on cooking factors, process and technic of steam cooking and steam cooking equipment. Cleveland Range Co., 3333 Lakeside Ave., Cleveland, Ohio. **(Key No. 1363)**

Burns. "The Triple-Dye Treatment of Burns," technical treatise on burns and their management, folder on Powder Dymixal and Jelly Dymixal and bibliography, McNiel Laboratories, Inc., 2900 N. 17th St., Philadelphia, Pa. **(Key No. 1369)**

Maintenance. "Fortify Your Pipe Lines Against Destructive Water Hammer," booklet giving helpful information with charts and illustrations for solving problem of water hammer in pipes and fixtures. American Skein & Foundry Co., Drainage Specialties Div., 420 N. LaSalle St., Chicago, Ill. **(Key No. 1692)**

Nursing Supplies. "Care and Conservation of Nursing Supplies," lecture prepared for the benefit of nursing classes. Meinecke & Co., Inc., 225 Varick St., New York, N. Y. **(Key No. 1044)**

Flooring. "Floors That Endure" and "Decorative Walls by Tile-Tex." Tile-Tex Co., Chicago Heights, Ill. **(Key No. 1158)**

Acoustics. Pamphlet describing Celotex Sound Conditioning. The Celotex Corp., 120 S. La Salle St., Chicago, Ill. **(Key No. 1156)**

PRINTED IN U. S. A.

BUYING INDEX

★ Indicates that further descriptive data are to be found in the current HOSPITAL YEARBOOK. This volume of reference data, plus the advertising pages of The MODERN HOSPITAL, constitutes the recognized market place for equipment and materials for hospital construction, operation and maintenance. While it is not possible for the publisher to guarantee products, it is his obligation to extend advertising only to responsible manufacturers and this has always been the policy of The Modern Hospital Publishing Co., Inc.

INDEX TO ADVERTISERS AND PRODUCT INFORMATION

Commandos on the Infection Front!

On the blistering sands of Tunisia, in the steaming jungles of New Guinea, Infection is the ever-present, unseen enemy. Prime carriers of infection are bandages which are not sterile.

The reason there are more A.T.I. Steam-Clox in use throughout the world today than ever before, is because these handy little indicators give an accurate answer at the source. When you prepare packs or drums for Autoclaving—you should use a Steam-Clox Sterilization Indicator in each pack —for only through the 4-way reaction of the Steam-Clox can you tell quickly, efficiently and effectively if sterilization conditions in your Autoclave have been met—and to what degree.

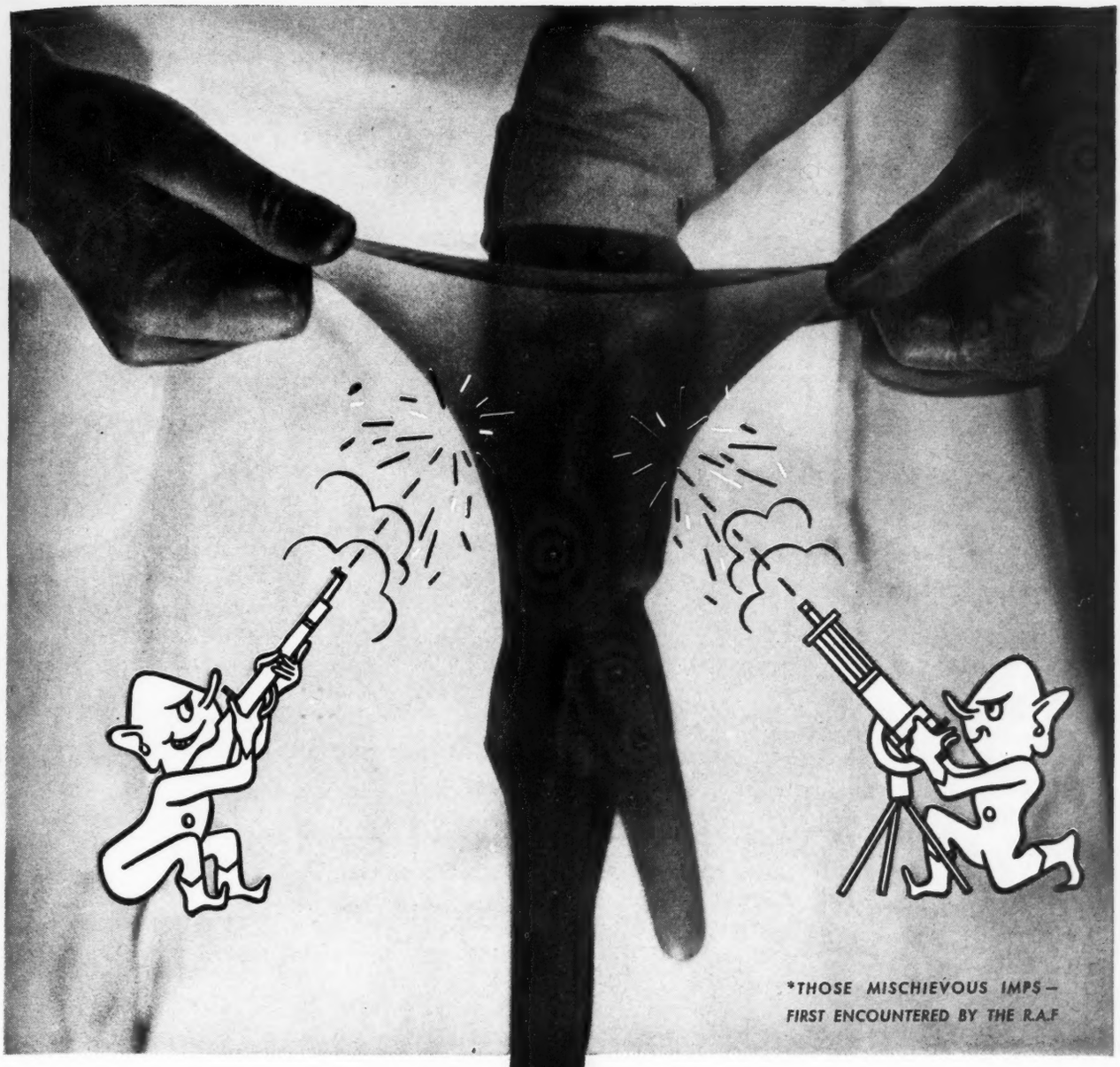
Place one A.T.I. Steam-Clox in each bundle every time you use your Autoclave. You will be protecting the lives of your patients—reducing the possibility of infection from unsterile bandages.

Check at the source—Use A.T.I. Steam-Clox—

ATI STEAM-CLOX

ASEPTIC-THERMO INDICATOR COMPANY

4665 Hollywood Boulevard · Los Angeles, California



SUDDEN DEATH . . . TO RUBBER!

You know the Commando Gremlins*—the sprites who destroy rubber whenever and wherever they can. Watchful for weak spots, they make slashing forays at the most unexpected moments. But "SR" SURGEONS' GLOVES present an impregnable target. For these famous gloves are made to withstand all the rigors of operating room and autoclave. They remain live and resilient long after ordinary gloves have been relegated to the scrap pile. Yet withal, their extreme durability, their perfect fit and tissue thin texture afford bare-hand comfort and sensitivity. In the interests of economy and conservation, specify "SR" SURGEONS' GLOVES to your Hospital Supply House. . . . Three types: Brown Milled with banded wrist, White Latex and Brown Latex.

Conserve rubber, do your share . . . better care means longer wear

The SEAMLESS SR RUBBER Company
NEW HAVEN, CONN., U.S.A. FINE RUBBER GOODS SINCE 1877
REG. U.S. PAT. OFF.

Dietary Adjustment in Wartime Deficiency States

PROMPT correction of frank or subclinical deficiency disease may call for therapy with high potency vitamin preparations. To prevent recurrence is a matter of adjusting the dietary to include adequate amounts of foods rich in the nutritional essentials needed.

Capricious appetite, frequently an important etiologic factor, may become more difficult to deal with as wartime curtailment of civilian food supplies becomes more drastic, and as appetite-stimulating foods become less available. In many instances adjustment of the dietary will call for detailed instruction of the patient and his household by the physician.

Meat remains the mainspring of the American meal, a big factor in appetite stimulation. Reduced availability should affect its presence in the meal only quantitatively. By "stretching" the amount available*; by extending its appetite-inducing flavor over collateral foods*; by the use of heretofore unfamiliar cuts*, wartime diets can be made deliciously tempting, assuring adequate intake of the proteins, vitamins, and minerals to which meat so richly contributes.

*A newly issued leaflet presenting wartime recipes and instructions regarding unfamiliar cuts of meat is rapidly gaining wide distribution. Physicians will find it helpful in their advice to patients requiring dietary adjustment. A complimentary copy will be mailed upon request.

The Seal of Acceptance denotes that the statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

American Meat Institute

CHICAGO

Millions of Meals *"double-quick"—that's what it takes to feed the sailors in Uncle Sam's Navy, the* best-fed *Navy in the world! And the United States Navy has found from experience that there is thrift, speed, cleanliness and convenience in Hotpoint-Edison Electric Galley Equipment! For experience has proved that cooking the safe, quick electrical way conserves food, vitamins and manpower!*

How Meals at Sea Have Helped Hospital Kitchens

IF YOU'RE a dietitian, and lucky enough to visit a modern ship's galley, you may be pardoned for being a bit envious.

For kitchens afloat aren't the only ones that need to save floor space. Or need to be kept clean and shipshape easily, or need to operate economically.

Yes, and for kitchens on land as well as on sea, it is important to avoid fire hazard. That is something unknown to Hotpoint-Edison Electric Kitchens, because they have no flame.

Nearly all ships of our Navy and Maritime Commission are now fitted with Hotpoint-Edison Electric Galleys. Simple and sturdy in design, they need less repairing. Having no flame, they burn almost no oxygen—a great help where there's a ventilation problem. And above all, they are durable, because of their uncompromising QUALITY. Quality in the vital parts—heating units, switches, wiring and connections.

You'll find a great satisfaction in the very appearance of Hotpoint-Edison Electric Cooking Equipment. Modern as tomorrow, smart as a new ensign, completely functional. A glance tells you that it's practical as a gun turret.

Many reasons for their use on ships may apply to *your* post-war needs. Though war priorities prevent your buying Hotpoint equipment now, it's not too early to plan. Let us help you visualize the streamlined kitchen you'll have when Victory comes. Edison General Electric Appliance Co., Inc., 5662 W. Taylor St., Chicago.

Send Today For This Free Book

Every Hotpoint-Edison user should study the valuable information in our new book, "How to Make the Most of Your Hotpoint-Edison Electric Kitchen." It contains many suggestions for saving food and fuel and prolonging the life of this valuable equipment.

For outstanding achievement ARMY E NAVY in War Production

FOUND ONLY IN MODERN KITCHENS

Hotpoint Edison

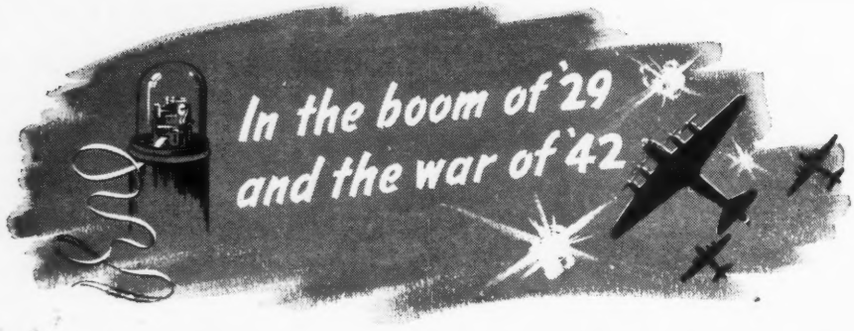
COMMERCIAL ELECTRIC COOKING EQUIPMENT

BOSTON NEW YORK CITY ATLANTA CLEVELAND CHICAGO KANSAS CITY DALLAS LOS ANGELES SEATTLE SALT LAKE CITY

CANADA—Canadian General Electric Company, Ltd., Toronto

OLDEST AND LARGEST MAKER OF ELECTRIC COOKING EQUIPMENT

FOR VICTORY — BUY U. S. WAR BONDS AND STAMPS



THESE MONEL WASHERS HAVE OPERATED DAY IN AND DAY OUT WITH PRACTICALLY NO REPAIRS

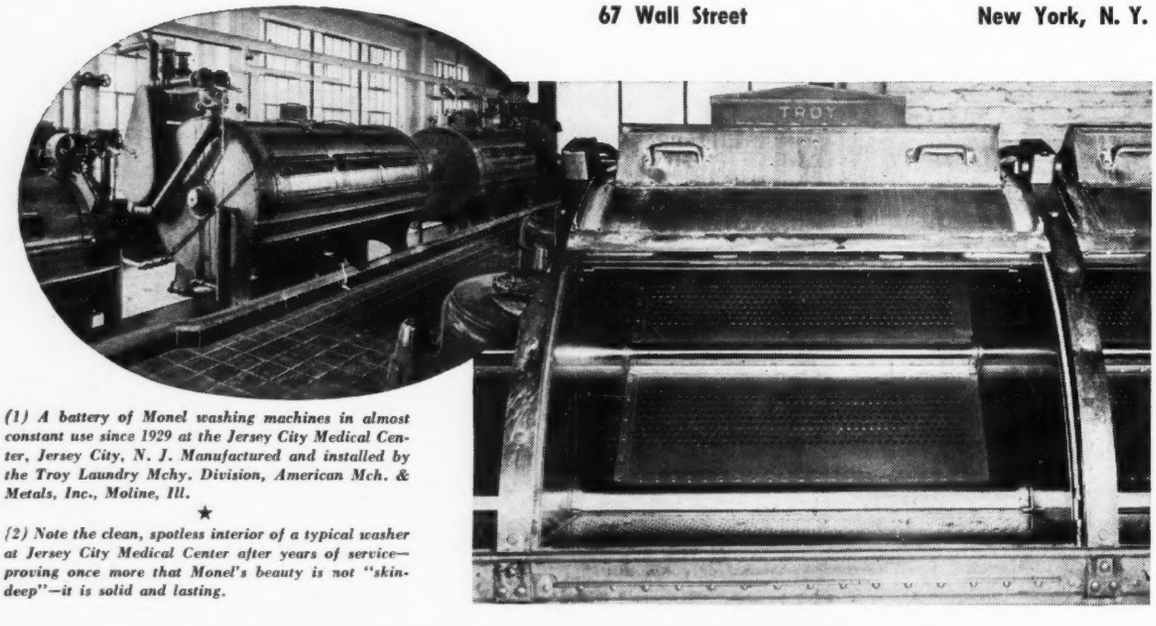
One thing the Jersey City Medical Center does not have to worry about during the war is the performance of its washing machines.

All 12 of them have been in almost daily use for fourteen years—yet shut-downs for repairs haven't been "worth talking about."

With such washer performance, Jersey City Medical Center is making no mistake in expecting them to keep up the good work for many more years. Here's the explanation for this reliable, trouble-free service. Those machines are made of Monel—and that means every quality you want in a hospital washer: toughness which makes for wear-resistance; rust immunity and corrosion resistance which means sanitation and cleanliness; and strength which permits construction for greater washer capacity per foot of floor-space.

The same properties that make Monel so *desirable* in hospital equipment, make it *vital* to our armed forces. That's why *they* are now taking the entire output of this durable metal and why institutions desiring the best in laundry, clinical and food equipment will be willing to wait until Victory makes Monel available once more.

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street **New York, N. Y.**



(1) A battery of Monel washing machines in almost constant use since 1929 at the Jersey City Medical Center, Jersey City, N. J. Manufactured and installed by the Troy Laundry Mchy. Division, American Mch. & Metals, Inc., Moline, Ill.

★

(2) Note the clean, spotless interior of a typical washer at Jersey City Medical Center after years of service—proving once more that Monel's beauty is not "skin-deep"—it is solid and lasting.

★ ★ ★ ★ ★ **INCO NICKEL ALLOYS** ★ ★ ★ ★ ★

MONEL • "K" MONEL • "S" MONEL • "R" MONEL • "KR" MONEL • INCONEL • NICKEL • "Z" NICKEL

Sheet... Strip... Rod... Tubing... Wire... Castings

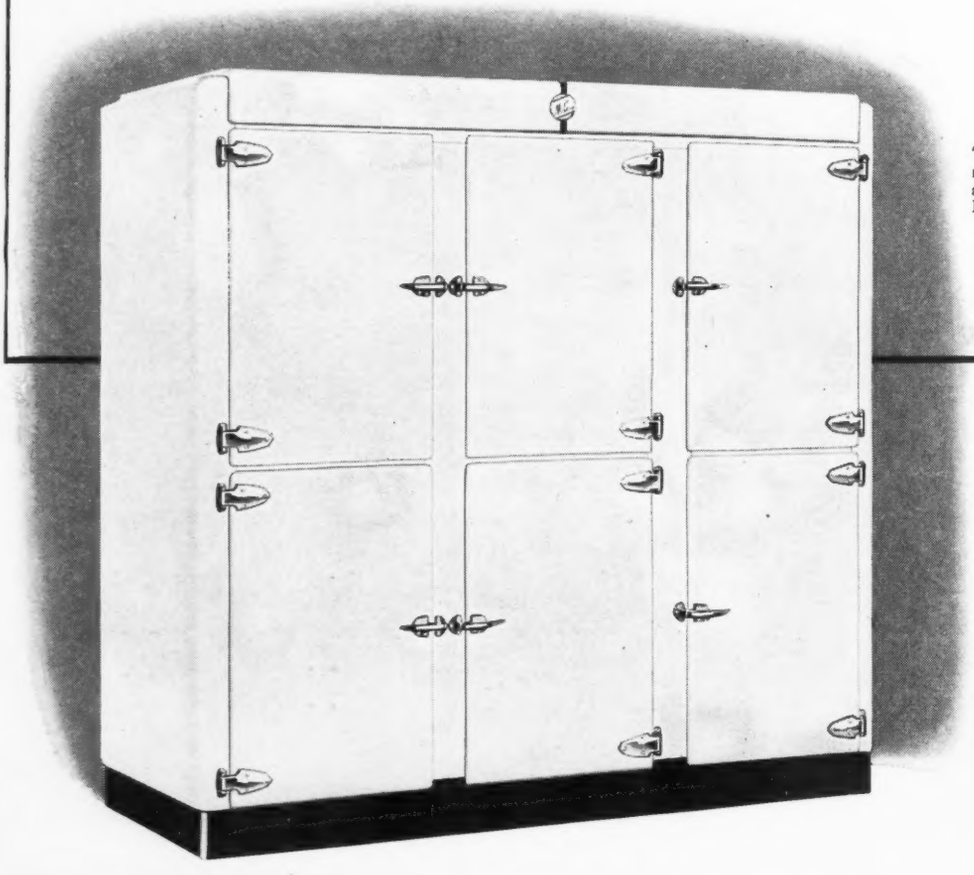
McCRAY

REFRIGERATORS *Save* FOOD

★ With shortages already occuring and food one of our most critical resources, it is clear that every possible means must be taken to prevent spoilage. Perishables, especially, rate the most efficient refrigeration, to keep them wholesome and nutritious, to avoid loss.

McCray storage refrigerators, in various sizes and types, will keep your stocks fresh and pure, prevent spoilage loss, and cut operating costs. McCray Triple Balanced Refrigeration is economical as well as efficient.

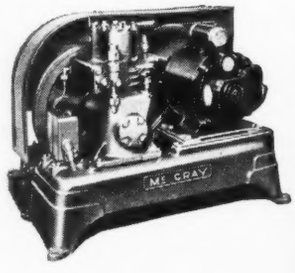
It's patriotic to check your refrigerators now—to replace wasteful or inadequate equipment. The McCray man will gladly help you—and explain priority regulations under which you can get needed new equipment. Write now.



☆

This 6-door McCray wall cabinet refrigerator provides generous storage space and convenient access. Refrigerators and coolers in many sizes still available to meet your needs.

McCray compressors, coils and cabinets are designed and engineered for use together, insuring efficient, economical service.



McCRAY REFRIGERATOR COMPANY

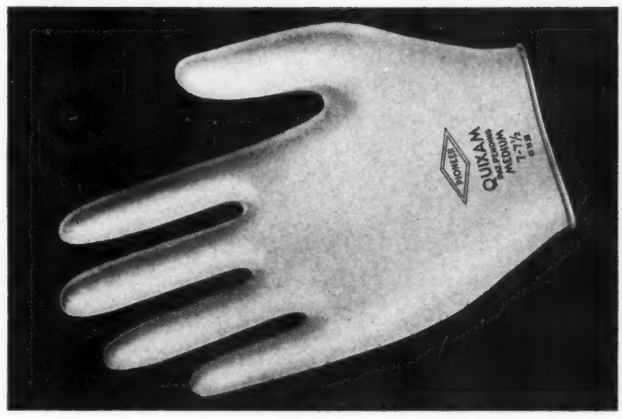
366 McCRAY COURT, KENDALLVILLE, INDIANA

SALESROOMS IN ALL PRINCIPAL CITIES — SEE TELEPHONE DIRECTORY

QUIXAM

Pioneer's Short Either-Hand Examination Glove Reduces Your Glove Expense, Saves Hospital Time and Labor

Your problems these days with expense budgets but especially with staff and personnel shortages make it important not to overlook even relatively small ways of helping to solve them. This remarkable Pioneer glove, already widely popular with hospitals and physicians, offers you 6 helpful advantages.

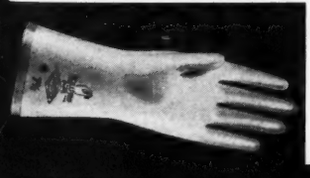


1. **Quixams Cost Less...** You buy one Quixam instead of a pair — and it costs less than half as much as a pair of regular surgical gloves.
2. **Reduce Necessary Stock...** A Quixam fits either hand — made for examinations and treatments where only one glove is required. Comes in 3 sizes only, large, medium, small — much smaller stock investment required.
3. **Easier for the Doctor...** Short wrist makes Quixam easy on. First glove doctor picks up is either right or left hand, saving time.
4. **Quixams Save Work...** No turning or pairing—important to short-handed hospitals.
5. **Prevent Waste...** No broken pairs. Quixams also save critical rubber because of this and the short wrist.
6. **Quixams Are Sheer and Durable...** Pioneer's special process makes these fine Latex Surgical Gloves equal to any in finger-tip sensitivity and extra tough to stand *more* trips to the autoclave.

Try Quixams — you'll find the staff approving them and the expense and work they save worth while. Ask your usual supplier or write us.

ROLLPRUF Surgical Gloves
now cost no more than good grade rolled gloves!

The exclusive flat-banded gloves that won't roll down to annoy the surgeon while operating.



Neoprene Rollprufs have been found to relieve dermatitis of the hands caused by an allergen in natural rubber.

THE PIONEER RUBBER COMPANY
Manufacturers of Surgical Gloves for More than 20 Years
240 Tiffin Road Willard, Ohio
New York • Los Angeles

Pioneer
EXAMINATION GLOVE

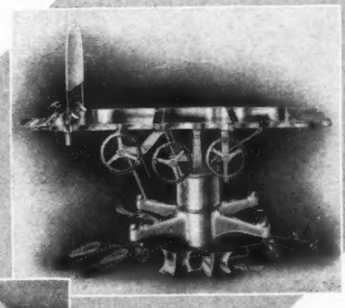
BUY A BOND TODAY...

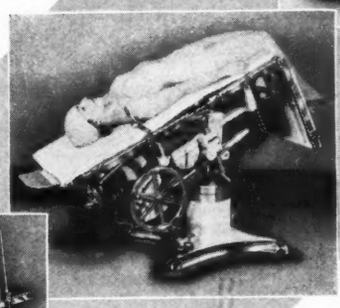
WHEN VICTORY IS WON
USE IT FOR NEW
WOCHER OPERATING EQUIPMENT

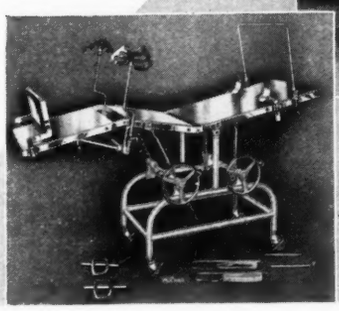
For every hospital, as for every industry and every man, woman, and child in the land, one thing is REALLY important today—Victory. And because of the immense sums of money necessary to equip our fighting forces, one "buy" is of FIRST importance —U. S. WAR BONDS.

So we make this suggestion. Take the money you've laid aside for that new Wocher Operating Equipment and invest it, instead, in a U. S. War Bond. "Earmark" that Bond for the Wocher Equipment you want—then *GET* it after the war is won.

This way, you'll be making the wisest possible investment. You'll be helping to speed the day of Victory . . . and when that day arrives, you'll have even finer, more efficient Wocher Operating Equipment than any of the past, due to improvements growing out of our intensive war-production experience and research.





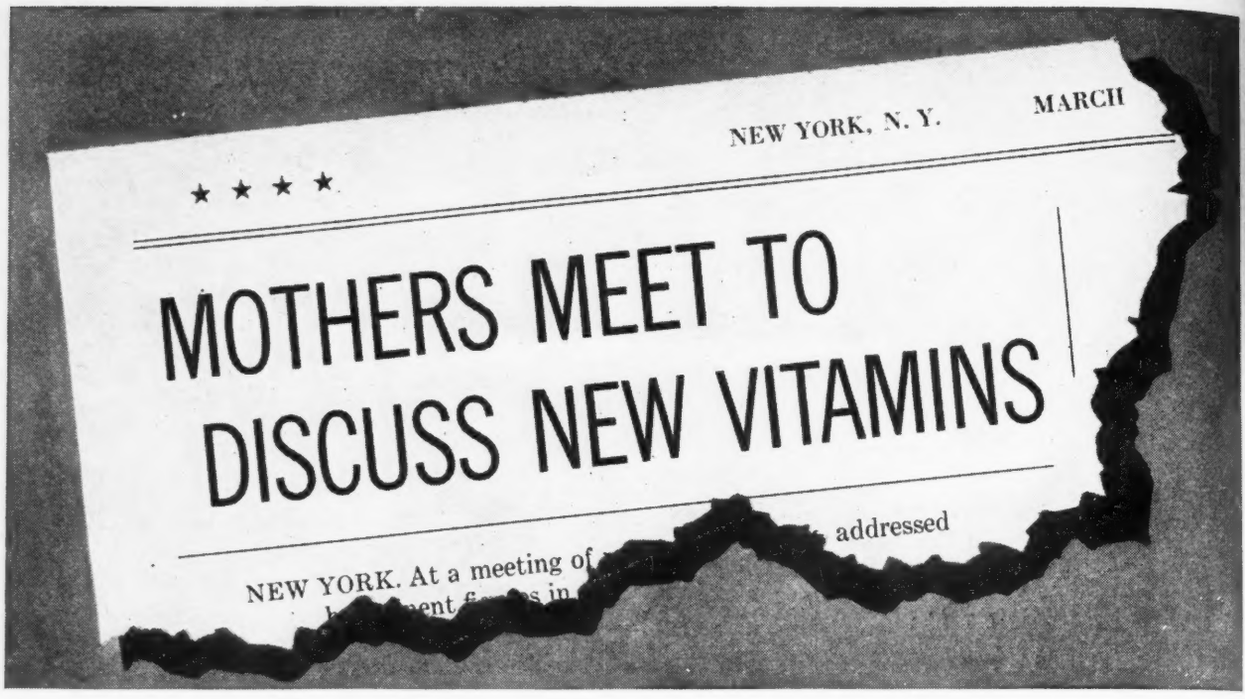


Wocher's

The Max Wocher & Son Co.
Makers of Surgical Instruments and Furniture
29-31 W. 6th St.
CINCINNATI, OHIO

Illustrations: reading down
Senior Operating Table
Mont R. Reid Operating Table
Universal Army Table

THE NUTRITION CLINIC...*with special reference to canned foods*



When your patients ask about vitamins...

WHEN the daily papers report on the forward march of medicine, the physician frequently hears echoes from his patients.

For example, "Should the new vitamins be included in my diet?" is not an improbable question for an intelligent patient to ask you.

Our Nutrition Laboratories, keeping abreast of the literature, have prepared an answer. It is given below. The references also are given. It is hoped that this material will be useful to you.

"THE STATUS in human nutrition of certain of the less well-known vitamins has not yet been definitely established. (1) Although it is quite likely that certain of these lesser-known factors—or other factors not yet postulated—play important roles in human nutrition, it is unlikely that a varied diet, including canned foods, which supplies optimal amounts of the better-known factors, will be deficient with respect to the less-known vitamins." (1) *What are the Vitamins?*, W. H. Eddy, Reinhold Publishing Corp., New York, 1941.

AMERICAN CAN COMPANY

230 PARK AVENUE, NEW YORK

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

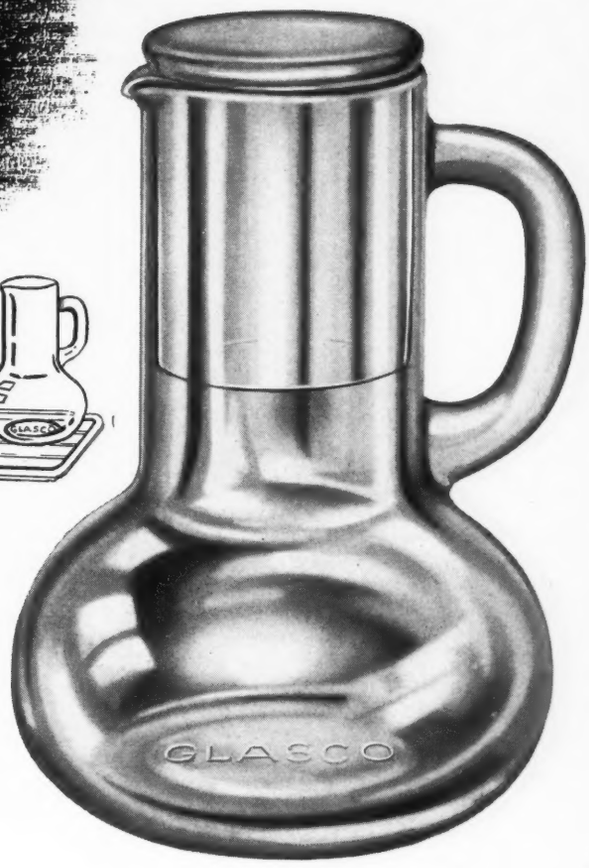
The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

NEW...

The TUMBLER-TOP PITCHER SET AND TRAY

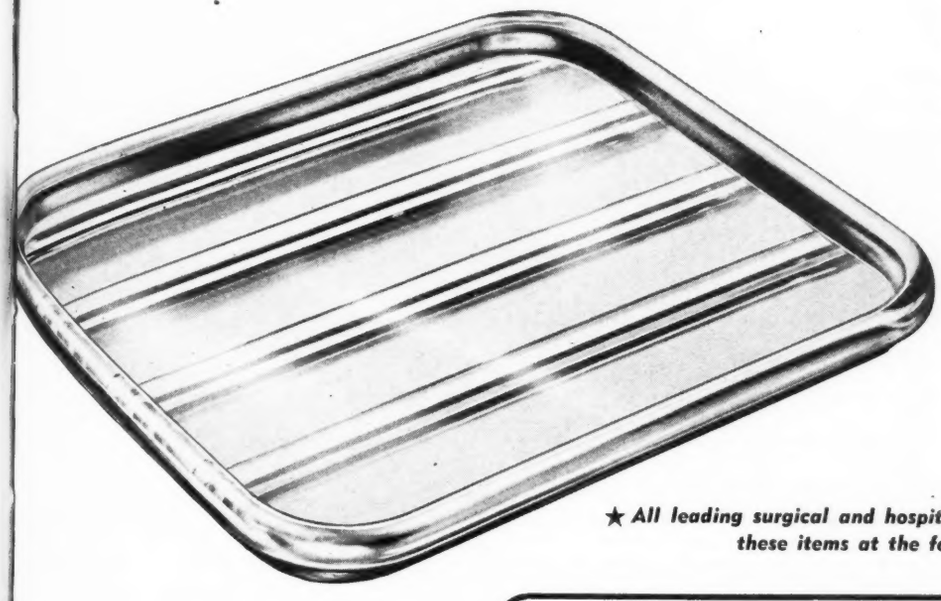
★

Saves essential war materials



Due to the scarcity of metal we are endeavoring to fill the hospital needs for water pitchers and trays in glass of a high quality and at a low price.

SANITARY
COMPACT
CONVENIENT
ECONOMICAL



No. 4750 consists of Pitcher and Tumbler, produced from the same glass as many of our fine surgical glassware items. It has a capacity of 1 quart and comes with a tumbler that acts as a cover. We feel sure that a review of the prices listed below will convince you that Glasco has again produced an article of fine quality at the lowest price on the market. This set does not include the tray.

★ *All leading surgical and hospital supply houses can deliver these items at the following prices:*

No. 2715 Glass Tray measures 9½" x 8½" and is ideal as a combination with our pitcher or as an instrument tray.

	No. 4750 PITCHER AND TUMBLER COMBINATION	No. 4750-1 PITCHER Only	No. 4750-2 TUMBLER Only	No. 2715 TRAY
Per Dozen	$9.00	$6.00	$3.00	$5.00
3 DOZEN LOTS Per Dozen	8.10	5.40	2.70	4.50
6 DOZEN LOTS Per Dozen	7.20	4.80	2.40	4.00
GROSS LOTS Per Dozen	6.75	4.50	2.25	3.75

Glasco Products Company 111 N. CANAL ST. • CHICAGO, ILL.

Despite demands for war materiel on overseas battlegrounds, supply ships cannot safely be loaded beyond their capacity. Antiseptics, too, are definitely not safe if the concentration required to achieve the necessary disinfection causes tissue irritation. Safety in antiseptics is largely determined by the delicate balance between antiseptic power and relative freedom from irritating qualities. Because Tincture Metaphen 1:200 maintains this essential balance and embodies other important features as well, it is widely selected by surgeons as a preoperative antiseptic. On the oral mucosa, two impartial investigators* found that *Tincture Metaphen 1:200 reduced bacterial count 95 to 100% within five minutes; produced only slight irritation in some cases, none in others; and had, in substantial excess over any of the 15 commonly-used antiseptics tested, a two-hour duration of action.* ● In addition, Tincture Metaphen does not appreciably precipitate blood serum; does not affect surgical instruments or rubber gloves; and is quite stable when exposed to air. Tincture Metaphen, *tinted* or *untinted*, is available in 1-fluidounce, 4-fluidounce, 1-pint and 1-gallon bottles. ABBOTT LABORATORIES, North Chicago, Illinois.

*Meyer, E., and Arnold, L. (1938) *American Journal Digest. Dis.*, 5:410.

(Tincture of 4-nitro-anhydro-hydroxy-mercury-orthocresol, Abbott)

Tincture Metaphen

REG. U. S. PAT. OFF.

TOMORROW'S SUTURE... TODAY

• Ranking with many important advances in medical science, Johnson & Johnson announces that Ethicon Catgut Sutures now possess new, exclusive, outstanding improvements.

Today the Ethicon label, in the operating room and in your dealer's stocks, is your assurance of these new features to serve the skill of your most exacting surgeons:

√ Greater, more uniform tensile strength, made possible by Ethicon's exclusive Tru-Gauging process, which prevents wide gauge variations.

√ Ethicon's exclusive Lock-Knot Finish, which helps to anchor your knots firmly and to hold them securely with minimum knot-tying traction.

√ Resistance to premature absorption, an advantage of Ethicon's Tru-Chromicizing process, by which the strand is uniformly permeated with digestion-resisting chrome.

Anticipating post-war progress in the art of surgery, Ethicon has developed the suture of the future, for your use today.

ETHICON
LOCK KNOT
SUTURES

ETHICON SUTURE DIVISION
OF JOHNSON & JOHNSON
New Brunswick, N. J.

"For leadership . . . for quality . . . for service."

ARMY E NAVY

Now the Dietitian has Relative Army Rank!

. . . and the GAS industry pays tribute to this great profession for its role in good nutrition

Dietitians, like nurses, have been serving with our armed forces for some time, but now they are being given appointments and soon will be outfitted in a military uniform of their own.

We of the Gas industry salute the members of this growing profession. Starting in the hospital field with care of the sick, they have branched out into all conceivable fields related to keeping people well through better nutrition. And now, in the Army, as appointed officers, their responsibility that of more nutritious food, they have an unparalleled opportunity to share in achieving victory.

At home, the hard-worked dietitians in our hospitals (working without military rank) face a challenge, too, in keeping present cooking equipment in good operating order. For any help needed in this respect, call your Gas company today.

AMERICAN GAS ASSOCIATION
INDUSTRIAL AND COMMERCIAL GAS SECTION
420 LEXINGTON AVENUE, NEW YORK

THE TREND IS TO GAS
FOR ALL COMMERCIAL COOKING

SPRING AIR
MATTRESSES

SELECT THE TYPE BEST SUITED TO YOUR NEEDS

— NO REASON TO WAIT

There is every probability that your hospital qualifies under existing regulations for Spring-Air Mattresses made to your specifications with the GENUINE KARR SPRING CONSTRUCTION — same full spring count and guaranteed quality as always. Our specialized knowledge and long experience of building hospital mattresses for the finest institutions of the country make Spring-Air the right source to come to for your requirements. It is advisable from every standpoint to make inquiry concerning the details NOW.

SPRING-AIR COMPANY
HOLLAND, MICHIGAN

42 Factories Coast to Coast

1 — Two-Layer Type with separate compartment pad and the

GENUINE KARR SPRING UNIT

2 — Inner Spring Type with special "Smooth edge" tailoring and containing the guaranteed full-count

KARR SPRING CONSTRUCTION

3 — Cotton-Filled Type embodying new and highly desirable construction features — 100% tuftless

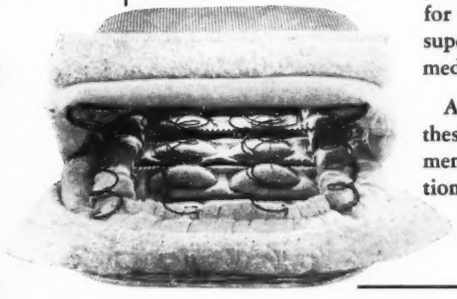
PRIORITY-FREE

NOTE: Type 3 Spring-Air is especially suitable for nurses' quarters — Can be supplied without restrictions or delay

In 1927 a certain division of the government purchased six Spring-Air Hospital Mattresses for testing. Over a few years 105 more were purchased for comparative testing under various conditions of climate and use.

In 1934 an order was placed for 2,500 Spring-Air mattresses for a year's trial use on the beds of supervisors, superintendents, and the medical staff.

After one year of further testing by these groups this particular government division drew up its specifications, under which more than 46,000 Spring-Air mattresses have since been used.



GET DETAILS NOW

LET US SEND YOU FULL INFORMATION — WRITE TODAY
FILL OUT AND SEND TO SPRING-AIR CO., HOLLAND, MICH.

NAME OF HOSPITAL

CITY AND STATE

ATTENTION OF

Saved—$1216.80 a year in Laundry Costs

These figures are actual savings in laundry costs—not theory. The savings is the difference between the cost of laundering the combination uniform MH 718 illustrated and the usual uniform ensemble of uniforms, aprons, bibs, collars and cuffs. The combination uniform MH 718 is all in one piece.

This patented uniform MH 718 saves $20.28 a year laundry cost per student nurse. The saving of $1216.80 is for a hospital having a school of 60 student nurses. Multiply $20.28 by the number of students in your school and you will have *your* saving per year.

This Uniform Relieves the Help Situation

There's another saving—the saving of labor. That's worth considering with the help situation as it is today. This one-piece uniform requires less handling than the equivalent uniform ensemble of uniform, apron, bib, collar and cuffs. It's a case of handling one piece instead of six. So you have a saving in labor and a consequent saving in money.

You'll like MH 718. It's comfortable. It's attractive. Excellently styled, well tailored of high quality material.

MARVIN-NEITZEL CORP.

Established 1845

TROY—NEW YORK

MH 718

Patented United States Patent 2,287,753

Clip this Coupon for MH 718 and Laundry Savings

MARVIN-NEITZEL CORPORATION, Troy, New York

Please send us MH 718 and the figures proving laundry savings for our inspection. Attached is clipping of our uniform material.

Signed..... *Position*.....

Hospital..... *Address*.....

That they, too, may serve...

RECOGNITION of the importance of X-Rays as a weapon of war and safeguard of health has impelled many of our young men and women to direct their time and talents toward intensive study of this valuable contribution to medicine.

To these wartime medical students we owe especial gratitude for the battle they've accepted . . . not the battle of bullets and bombs . . . but the battle to complete their training faster and speed their entry into our army of Men *and Women* in White. Because of their valuable understanding of X-Ray diagnosis, America shall know better health and more comfort as well as peace in a world which has brought the triumph of victory to its common people.

To these future doctors and technicians, whether in military service or civilian practice, we renew our pledge that Patterson research and manufacturing facilities are keyed to the demands of the war emergency . . . that we are doing our part towards an adequate supply of Intensifying and Fluoroscopic Screens and that we can assure them of maximum standards of quality in Patterson Screens.

THE PATTERSON SCREEN COMPANY, TOWANDA, PA., U. S. A.

Patterson Screens *Light the paths of X-Ray*

PATTERSON'S FACILITIES ARE DEVOTED 100% TO PUBLIC HEALTH AND THE FIGHTING FORCES OF THE UNITED NATIONS

FIVE NEW CHARTS

to help you teach new employees to save Fuel and Food

Immediate help to solve these kitchen problems is right at hand if your ovens, steam tables, fryers and coffee urns are equipped with Robertshaw thermostats. These thermostats were made and installed to take the guesswork out of cooking—these charts will help teach inexperienced employees.

These charts tell how to get more servings from roasts by reducing meat shrinkage; how to insure uniform, good quality baked goods; how to improve quality of fried goods while saving frying oil; how to produce better brews while saving coffee and fuel; how to operate steam tables for best results with minimum consumption of fuel. Each is ten inches by fifteen inches, printed in two colors on durable cardboard—easy to read and simple to follow.

Send for your set of these five new charts today. The only charge is twenty-five cents to cover printing and mailing. Just fill out and mail the handy coupon below.

ROBERTSHAW

THERMOSTAT COMPANY

ROBERTSHAW THERMOSTAT CO. MH 1
30 Church St., New York, N.Y.

Please send me the set of five instruction charts to help teach inexperienced employees to save food, fuel and vitamins. I enclose twenty-five cents to cover printing and mailing costs.

*Name*_____

*Firm Name*_____

*Street*_____ *City & State*_____

Conservation *can't* mean SKIMPING

CURITY ABDOMINAL PADS DO SAVE SUPPLIES . . . AND MONEY

They're highly absorbent . . . fewer are needed . . . and *this* saves precious material.

They retain more moisture so changes are not as frequent . . . and *this* saves nursing time.

They retard leakage . . . and *this* saves soiled binders and gowns and bedclothes.

They cost no more than the pads you're using now . . . and *that* saves money.

**Placards like the one on the dressing cart are yours for the asking. Your Curity representative has them for you.*

You simply can't save on supplies at the expense of your high and honest service standards . . . you wouldn't if you could.

Conservation has to mean more careful use . . . more rigid planning . . . *and* (note this) the use of dressings that will do the job better.

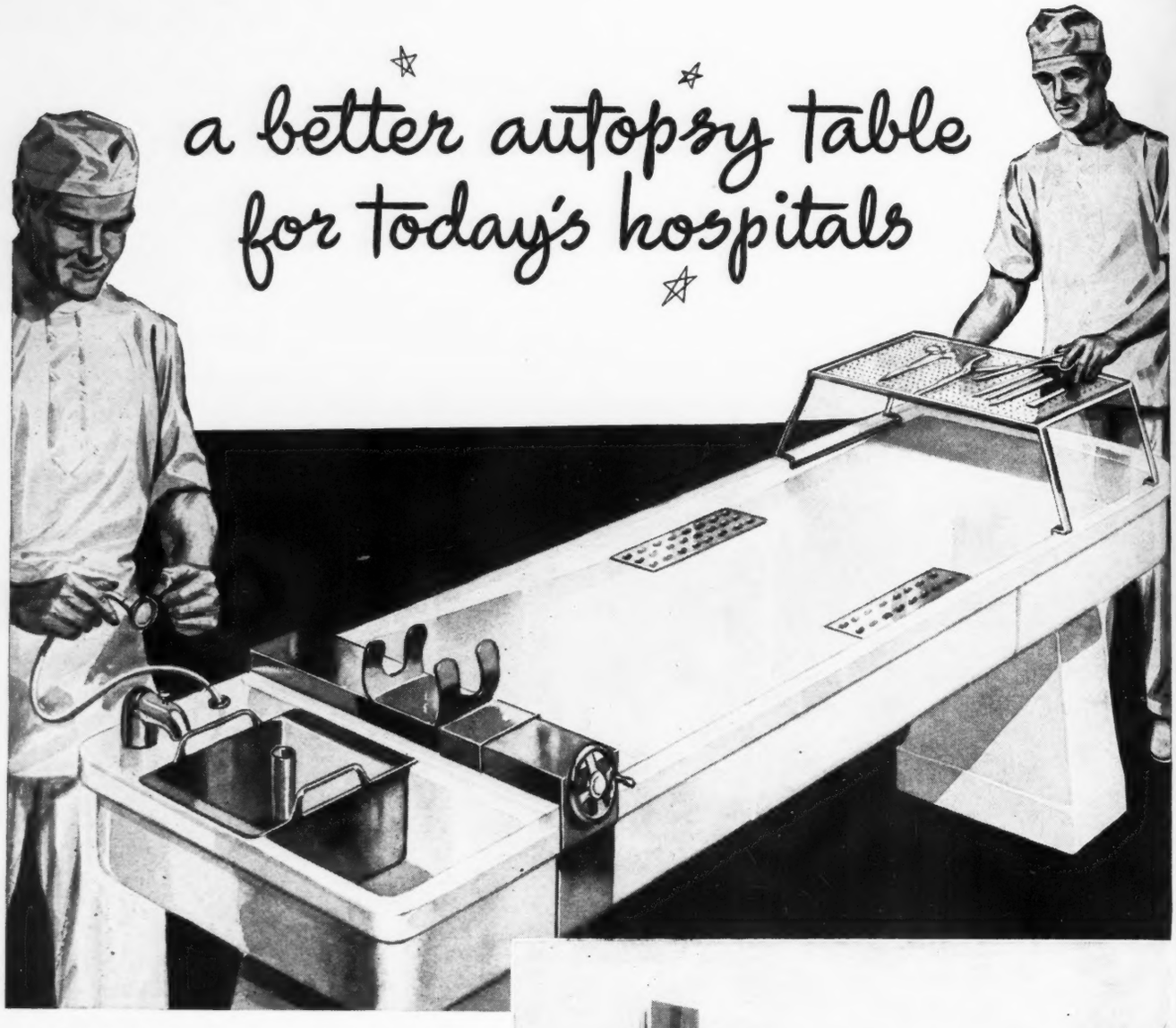
A case in point . . . one of dozens we could name: Curity Abdominal Pads . . . scientifically *engineered* to absorb fast . . . to diffuse discharges *evenly* . . . to *retain* moisture . . . to *retard* leakage . . . to reduce the *number* of dressing changes. Curity Abdominal Pads are built up of successive layers of gauze, Cellucotton and absorbent cotton in proper sequence and thickness to do all these things . . . to help you SAVE SUPPLIES, nursing time and money.

Six standard sizes meet nearly every postoperative dressings need—30x8, 24x8, 24x10, 10x8, 12x10, 16x12.

Curity
REG. U.S. PAT. OFF.

BAUER & BLACK Division of The Kendall Company Chicago

a better autopsy table for today's hospitals



RECENTLY developed, this modern table materially aids autopsy technique. Made of Duraclay, a vitreous glazed earthenware, it assures maximum sanitation, at the same time conserving critical metals. There are no corners or crevices to harbor dirt or germs, and the twin waste outlets are located to permit free, unobstructed drainage. Throughout, this table has been designed to facilitate the work of pathologists.

A thermostatic mixing valve assures water of an even predetermined temperature and a vacuum breaker in the transfer spout prevents any danger of back-siphonage. May be equipped as shown or without head clamp, instrument tray and specimen basin. This modern Duraclay autopsy table is ideally suited to Army, Navy or civilian hospitals. It is one item from the complete Crane line of specially designed hospital equipment.

The Welfare Island Hospital at Long Island, New York, is an outstanding example of modern hospital design. Like many other hospitals large and small throughout the country, it is completely equipped with Crane plumbing.

CRANE

CRANE CO., GENERAL OFFICES: 836 S. MICHIGAN AVE., CHICAGO

VALVES • FITTINGS • PIPE • PLUMBING • HEATING • PUMPS

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

"Sure, it's the Boss' office...but, is this the Boss?"

If you want more time to run your business, let us run ours. We refer to your refrigeration plant and to our Certified Maintenance Contract.

You don't have to get into overalls, even figuratively, when you enjoy this comprehensive, *preventive* service. York-trained experts tune up your plant to concert pitch *and keep it that way*. You are protected against breakdowns. spared the job of shopping for renewal parts, motors, belts, refrigerant, valves and fittings, insulating materials. And by maintaining high operating efficiency, you start saving money right away on power and water.

If refrigeration is vital to your business, you'd better let experts look after it. Don't wait for trouble. Send the coupon today and get complete information . . . post haste. York Ice Machinery Corporation, York, Pennsylvania.

YORK REFRIGERATION AND AIR CONDITIONING FOR WAR

HEADQUARTERS FOR MECHANICAL COOLING SINCE 1885

york refrigeration air conditioning **Certified MAINTENANCE**

YORK ICE MACHINERY CORP., YORK, PENNA. MH-6

I am interested in learning more about the York Certified Maintenance Contract.

Name_____ Position_____

Co. Name_____

Street & No._____

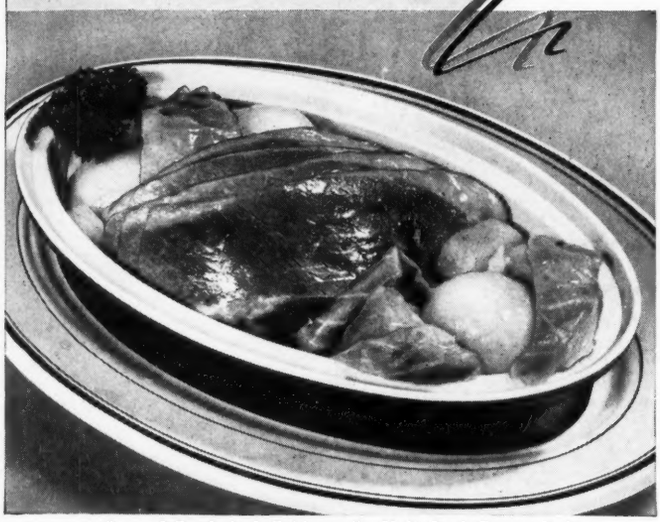
City_____ State_____

INDEX to VOLUME 60

JANUARY to JUNE INCLUSIVE

The various articles are indexed under the author and subject. Abbreviations used in this index are: Ja, January; F, February; Mr, March; Ap, April; My, May; J, June; (Ed.), editorial; (E.Q.B.), Engineers' Question Box; (P.), portfolio; (S.H.F.), Small Hospital Forum, and (S.H.Q.), Small Hospital Questions.

"3 reasons why HALL CHINA IS PREFERRED FOR CASSEROLE COOKING"



Corned Beef And Cabbage In Hall Oval Casserole
An old favorite, individually served, reaches a new high in appetizing appeal . . . its rich, full flavor "sealed-in" by the gleaming, white walls of a Hall casserole.

Sweetbreads In Hall French Shirred Egg Dish
Good to look at and just as good to eat . . . creamed sweetbreads, Virginia style ham, and crisp vegetables topped with a piquant cream sauce . . . in a Hall China baking dish.

1

ASSURES PERFECT BAKING The heavy, fireproof walls of Hall Secret Process China diffuse direct oven heat so that all the contents of the casserole are subjected to an even, steady temperature. Food is thoroughly cooked. Flavor is rich, full, and unscorched. There are no burnt bottoms or edges while the inside is just half-done when Hall China is used.

2

KEEPS FOOD HOT Hall China "seals-in" the heat . . . and the flavor too—for the fine texture of its thick body retards heat loss, and completely prevents staining and absorption. The use of Hall China minimizes complaints about cold servings, "off-taste," and discoloration.

3

ALWAYS LOOKS "NEW" Hall China cannot craze and the color will not fade or wear away . . . for body, glaze, and color are fused together by an exclusive, secret process. Hall China resists chipping because it has a safety-measure of strength where it counts—in rims, lips, and handles. It is easy-to-clean and gleams like new even after long, hard use.

The Hall China Company, East Liverpool, Ohio
World's Largest Manufacturer of Fireproof Cooking China

GOOD RECIPES BEGIN WITH

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Secret Process
FIREPROOF CHINA

Celotex Sound Conditioning

Helps Patients Recover Faster In Over 800 Hospitals!

MOTHERS released from the day-long clamor of little children—business men hospitalized away from the nerve-wracking noises of war plants—often give silent thanks for the emergency which sends them to the blessed quiet of a modern hospital. Doctors and nurses give full credit to the benefits of Celotex Sound Conditioning in helping to speed recovery—benefits now shared by more than 800 hospitals!

There is, near you, an Acousti-Celotex distributor who is thoroughly familiar with hospital noise-quieting problems. He will be glad to give you the benefit of his wide experience—to offer his recommendations without obligation. When you buy sound conditioning from him, you are assured of (1) *Proved engineering practice,* (2) *Uniformly dependable sound conditioning materials,* and (3) *Guaranteed results!* Write today!

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Among the strong links which make up the nation-wide Celotex Sound Conditioning Organization is the Asbestos Supply Company of Seattle, Portland, Spokane, and Tacoma. This firm has completed over 3,000 successful installations since its establishment in 1925.

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